

103<sup>D</sup> CONGRESS  
1<sup>ST</sup> SESSION

# H. R. 834

To provide for comprehensive health care access expansion and cost control through reform and simplification of private health care insurance and other means.

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## IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 4, 1993

Mr. GLICKMAN (for himself and Mr. McCURDY) introduced the following bill; which was referred jointly to the Committees on Energy and Commerce, Ways and Means, the Judiciary, Education and Labor, and Rules

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## A BILL

To provide for comprehensive health care access expansion and cost control through reform and simplification of private health care insurance and other means.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

### 3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the  
5 “BasiCare Health Access and Cost Control Act”.

6 (b) TABLE OF CONTENTS.—The table of contents of  
7 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—IMMEDIATE REFORMS

Subtitle A—Small Employer Health Insurance Market Reform

- Sec. 101. General requirements.
- Sec. 102. General issuance requirements.
- Sec. 103. Specific contractual requirements.
- Sec. 104. State compliance agreements.
- Sec. 105. Definitions and other rules.
- Sec. 106. Amendment to the Internal Revenue Code of 1986.
- Sec. 107. Effective date.

Subtitle B—Community Health Services Expansion

- Sec. 111. Establishment of grant program.
- Sec. 112. Program to provide for expansion of federally qualified health centers.

Subtitle C—Expansion of Tax Incentives for Self-Employed Individuals

- Sec. 121. Permanent increase in deductible health insurance costs for self-employed individuals.

Subtitle D—Expanding the Supply of Health Professionals in Rural Areas

- Sec. 131. Expansion of National Health Service Corps.
- Sec. 132. Tax incentives for practice in rural areas.

Subtitle E—Malpractice Reform

PART I—DEFINITIONS

- Sec. 141. Definitions.

PART II—TORT REFORM OF HEALTH CARE LIABILITY ACTIONS

- Sec. 142. Application to civil actions.
- Sec. 143. Damages.
- Sec. 144. Joint and several liability.
- Sec. 145. Statute of limitations.
- Sec. 146. Preemption.
- Sec. 147. Effective date.

PART III—ALTERNATIVE DISPUTE RESOLUTION SYSTEMS

- Sec. 148. Grants for alternative dispute resolution systems.
- Sec. 149. Establishment of advisory panel.
- Sec. 150. Authorization.

PART IV—DEMONSTRATION PROJECTS FOR NO-FAULT COMPENSATION PROGRAMS

- Sec. 151. Demonstration projects for no-fault compensation programs.

Subtitle F—Joint Ventures

- Sec. 161. Amendment of the National Cooperative Research Act of 1984.

TITLE II—LONG-TERM REFORMS

Subtitle A—Establishment of Commission and Advisory Board

- Sec. 201. The Commission on National Health Care Access and Reform.

- Sec. 202. National Advisory Board.
- Sec. 203. Authorization of appropriations.

#### Subtitle B—Reform and Standardization of Private Insurance

- Sec. 211. Defining goals and guidelines of Commission.
- Sec. 212. Development and submission of legislative proposal.
- Sec. 213. Continuing duties and responsibilities of the Commission.
- Sec. 214. BasiCare benefits package.
- Sec. 215. Insurance responsibilities under BasiCare.
- Sec. 216. BasiCare base premium rate.
- Sec. 217. Employer responsibilities under BasiCare.
- Sec. 218. Individual responsibilities under BasiCare.
- Sec. 219. Self-insured plan requirements.
- Sec. 220. Provider responsibilities under BasiCare.
- Sec. 221. Development of standards for managed care plans.
- Sec. 222. Preemption of provisions relating to managed care.

#### Subtitle C—Low-Income Assistance

- Sec. 231. Transfer from medicaid to BasiCare.
- Sec. 232. Low-income assistance with costs of BasiCare insurance.

#### Subtitle D—Congressional Consideration of Commission Recommendation

- Sec. 241. Rules governing congressional consideration.

#### Subtitle E—Enforcement Provisions

- Sec. 251. Enforcement provisions for carriers, providers, and employers.
- Sec. 252. Enforcement provision for individuals.

#### Subtitle F—Financial Provisions

- Sec. 261. BasiCare Trust Fund.
- Sec. 262. Tax treatment of costs of BasiCare insurance.

#### Subtitle G—Definitions

- Sec. 271. Definitions.

## 1 **TITLE I—IMMEDIATE REFORMS**

### 2 **Subtitle A—Small Employer Health**

### 3 **Insurance Market Reform**

#### 4 **SEC. 101. GENERAL REQUIREMENTS.**

5 Any person issuing an accident and health insurance  
 6 contract to any small employer shall meet the require-  
 7 ments of sections 102 and 103.

1 **SEC. 102. GENERAL ISSUANCE REQUIREMENTS.**

2 (a) GENERAL RULE.—The requirements of this sec-  
3 tion are met if any person issuing an accident and health  
4 insurance contract to any small employer meets—

5 (1) the mandatory policy requirements of sub-  
6 section (b), and

7 (2) the guaranteed issue requirements of sub-  
8 section (c).

9 (b) MANDATORY POLICY REQUIREMENTS.—

10 (1) IN GENERAL.—The requirements of this  
11 subsection are met if any person issuing an accident  
12 and health insurance contract to any small employer  
13 makes available to such small employer an accident  
14 and health insurance contract which provides bene-  
15 fits which are identical to the core benefits described  
16 in subsection (d).

17 (2) PRICING AND MARKETING REQUIRE-  
18 MENTS.—The requirements of paragraph (1) are not  
19 met unless—

20 (A) the price at which the accident and  
21 health insurance contract is made available is  
22 not greater than the price for such contract de-  
23 termined on the same basis as prices for other  
24 accident and health insurance contracts within  
25 the same class of business made available by  
26 the person to small employers, and

1 (B) the accident and health insurance con-  
2 tract is made available to small employers using  
3 substantially the same marketing methods and  
4 other sales practices which are used in selling  
5 such other contracts.

6 (c) GUARANTEED ISSUE.—

7 (1) IN GENERAL.—The requirements of this  
8 subsection are met—

9 (A) if the person offering accident and  
10 health insurance contracts to small employers  
11 issues such contracts to any small employer  
12 seeking to enter into such a contract, and

13 (B) if the person offers a managed care ar-  
14 rangement in a State, or a geographic area  
15 within a State, to employers that are not small  
16 employers, the person offers such managed care  
17 arrangement to small employers in the State or  
18 geographic area.

19 (2) FINANCIAL CAPACITY EXCEPTION.—Para-  
20 graph (1)(A) shall not require any person to issue  
21 an accident and health insurance contract to the ex-  
22 tent that the issuance of such contract would result  
23 in such person violating any financial solvency  
24 standards established by the State in which such  
25 contract is to be issued.

1           (3) EXCEPTIONS FOR CERTAIN EMPLOYERS.—

2           Paragraph (1)(A) shall not apply to a failure to  
3           issue an accident and health insurance contract to a  
4           small employer if—

5                   (A) the small employer is unable to pay the  
6                   premium for such contract, or

7                   (B) in the case of a small employer with  
8                   fewer than 15 employees, such employer fails to  
9                   enroll at least 60 percent of the employer's eli-  
10                  gible employees for coverage under such con-  
11                  tract.

12           (4) SIZE LIMITS FOR MANAGED CARE ARRANGE-  
13           MENTS.—Paragraph (1)(B) shall not apply to any  
14           person who ceases to enroll new small employer  
15           groups in a managed care arrangement if it ceases  
16           to enroll any new employer groups in such arrange-  
17           ment.

18           (d) BENEFITS.—

19                   (1) CORE BENEFITS.—For purposes of this sec-  
20                   tion, the term “core benefits” means benefits which  
21                   are the same benefits provided as of the date of the  
22                   enactment of this Act under title XVIII of the Social  
23                   Security Act to individuals entitled to benefits under  
24                   part A, and enrolled for benefits under part B of  
25                   such title.

1           (2) DEDUCTIBLES AND COPAYMENTS.—An acci-  
2       dent and health insurance contract shall not be  
3       treated as providing the core benefits described in  
4       paragraph (1) unless the following requirements are  
5       met:

6           (A) DEDUCTIBLE.—The accident and  
7       health insurance contract does not require a de-  
8       ductible amount for any contract year in excess  
9       of \$500 per individual or \$1,000 per family  
10      with respect to the core benefits.

11          (B) LIMIT ON OUT-OF-POCKET EX-  
12      PENSES.—The accident and health insurance  
13      contract does not require out-of-pocket expenses  
14      for any contract year in excess of \$2,000 per  
15      individual or \$3,000 per family for the core  
16      benefits.

17          (C) CHILDREN.—

18           (i) NO DEDUCTIBLES OR COINSUR-  
19      ANCE.—In the case of children, there shall  
20      be no coinsurance, deductibles, or  
21      copayments applicable to covered benefits  
22      described in clause (ii).

23           (ii) ADDITIONAL PREVENTIVE BENE-  
24      FITS.—Subject to the periodicity schedule  
25      established under clause (iii), benefits shall

1 be available for children under the accident  
2 and health insurance contract for the fol-  
3 lowing items and services:

4 (I) Newborn and well-baby care,  
5 including normal newborn care and  
6 pediatrician services for high-risk de-  
7 liveries.

8 (II) Well-child care, including  
9 routine office visits, routine immuni-  
10 zations (including the vaccine itself),  
11 routine laboratory tests, and preven-  
12 tive dental care.

13 (iii) PERIODICITY SCHEDULE.—The  
14 Secretary, in consultation with the Amer-  
15 ican Academy of Pediatrics, shall establish  
16 a schedule of periodicity which reflects the  
17 general, appropriate frequency with which  
18 services listed in clause (ii) should be pro-  
19 vided to healthy children.

20 (iv) CHILD DEFINED.—For purposes  
21 of this subparagraph, the term “child”  
22 means an individual who has not attained  
23 age 23.

24 (D) PREGNANCY-RELATED SERVICES.—



1 (i) NO DEDUCTIBLES OR COINSUR-  
2 ANCE.—In the case of a pregnant woman,  
3 there shall be no coinsurance, deductibles,  
4 or copayments applicable to covered bene-  
5 fits described in clause (ii).

6 (ii) ADDITIONAL BENEFITS.—Subject  
7 to the periodicity schedule established  
8 under clause (iii), benefits shall be avail-  
9 able for pregnant women under the acci-  
10 dent and health insurance contract for the  
11 following items and services:

12 (I) Prenatal care, including care  
13 for all complications of pregnancy.

14 (II) Inpatient labor and delivery  
15 services.

16 (III) Postnatal care.

17 (IV) Postnatal family planning  
18 services.

19 (iii) PERIODICITY SCHEDULE.—The  
20 Secretary, in consultation with the Amer-  
21 ican College of Obstetrics and Gynecology,  
22 shall establish a schedule of periodicity  
23 which reflects the general, appropriate fre-  
24 quency with which services listed in clause

1 (ii) should be provided to pregnant women  
2 without complications of pregnancy.

3 (iv) PREGNANT WOMAN.—For pur-  
4 poses of this subparagraph, the term  
5 “pregnant woman” means a woman who  
6 has been certified by a physician (in a  
7 manner specified by the Secretary) as  
8 being pregnant and such woman shall be a  
9 pregnant woman for the purposes of this  
10 subparagraph until the last day of the  
11 month in which the 60-day period begin-  
12 ning on the date of termination of the  
13 pregnancy ends.

14 (3) PREEMPTION.—To the extent that the laws  
15 of any State or local government regulate or other-  
16 wise provide any requirement relating to the benefits  
17 to be provided under an accident and health insur-  
18 ance contract which are inconsistent with the provi-  
19 sions of this Act, they are preempted.

20 **SEC. 103. SPECIFIC CONTRACTUAL REQUIREMENTS.**

21 (a) GENERAL RULE.—The requirements of this sec-  
22 tion are met if any person issuing an accident and health  
23 insurance contract to any small employer meets—

24 (1) the coverage requirements of subsection (b),  
25 and

1 (2) the rating requirements of subsection (c).

2 (b) COVERAGE REQUIREMENTS.—

3 (1) IN GENERAL.—The requirements of this  
4 subsection are met with respect to any accident and  
5 health contract if, under the terms and operation of  
6 the contract, the following requirements are met:

7 (A) GUARANTEED ELIGIBILITY.—No eligi-  
8 ble employee (and the spouse or any dependent  
9 child (as defined in section 102(d)(2)(C)(iv)) of  
10 the employee eligible for coverage) may be ex-  
11 cluded from coverage under the contract.

12 (B) LIMITATIONS ON COVERAGE OF PRE-  
13 EXISTING CONDITIONS.—Any limitation under  
14 the contract on any preexisting condition—

15 (i) may not extend beyond the 6-  
16 month period beginning with the date an  
17 insured individual is first covered by the  
18 contract, and

19 (ii) may only apply to preexisting con-  
20 ditions which manifested themselves, or for  
21 which medical care or advice was sought or  
22 recommended, during the 3-month period  
23 preceding the date an insured individual is  
24 first covered by the contract.

25 (C) GUARANTEED RENEWABILITY.—

1 (i) IN GENERAL.—The contract must  
2 be renewed at the election of the small em-  
3 ployer unless the contract is terminated for  
4 cause.

5 (ii) CAUSE.—For purposes of this  
6 subparagraph, the term “cause”—

7 (I) includes nonpayment of pre-  
8 miums, fraud or misrepresentation,  
9 noncompliance with contract provi-  
10 sions (including participation require-  
11 ments), or misuse of network provi-  
12 sions, but

13 (II) does not include any reason  
14 related to risk characteristics.

15 (2) WAITING PERIODS.—Paragraph (1)(A) shall  
16 not apply to any period an eligible employee is ex-  
17 cluded from coverage under the contract solely by  
18 reason of a requirement applicable to all employees  
19 that a minimum period of service with the employer  
20 is required before the employee is eligible for such  
21 coverage.

22 (3) DETERMINATION OF PERIODS FOR RULES  
23 RELATING TO PREEXISTING CONDITIONS.—For pur-  
24 poses of paragraph (1)(B), the date on which an in-

1       sured individual is first covered by an accident and  
2       health insurance contract shall be the earlier of—

3               (A) the date on which coverage under such  
4       contract begins, or

5               (B) the first day of any continuous pe-  
6       riod—

7                       (i) during which the insured individual  
8       was covered under 1 or more other health  
9       insurance arrangements, and

10                      (ii) which does not end more than 120  
11       days before the date employment for the  
12       employer begins.

13       (4) CESSATION OF SMALL EMPLOYER HEALTH  
14       INSURANCE BUSINESS.—

15               (A) IN GENERAL.—Except as otherwise  
16       provided in this paragraph, a person shall not  
17       be treated as failing to meet the requirements  
18       of paragraph (1)(C) if such person terminates  
19       the class of business which includes the acci-  
20       dent and health insurance contract.

21               (B) NOTICE REQUIREMENT.—Subpara-  
22       graph (A) shall apply only if the person gives  
23       notice of the decision to terminate at least 90  
24       days before the expiration of the contract.

1 (C) 5-YEAR MORATORIUM.—If, within 5  
2 years of the year in which a person terminates  
3 a class of business under subparagraph (A),  
4 such person establishes a new class of business  
5 which includes contracts within the class of  
6 business so terminated, the issuance of such  
7 contracts in that year shall be treated as a fail-  
8 ure to meet the requirements of paragraph  
9 (1)(C).

10 (D) TRANSFERS.—If, upon a failure to  
11 renew a contract to which subparagraph (A)  
12 applies, a person transfers such contract to an-  
13 other class of business, such transfer must be  
14 made without regard to any risk characteristic.

15 (c) RATING REQUIREMENTS.—The requirements of  
16 this subsection are met with respect to any accident and  
17 health contract if the following requirements are met:

18 (1) LIMITATION ON VARIATION OF PREMIUMS  
19 BETWEEN CLASSES OF BUSINESS.—

20 (A) IN GENERAL.—The base premium rate  
21 for any class of business of a person issuing an  
22 accident and health insurance contract to a  
23 small employer may not exceed the base pre-  
24 mium rate for any other class of business by  
25 more than 20 percent.

1 (B) EXCEPTIONS.—Subparagraph (A)  
2 shall not apply to a class of business if the ap-  
3 plicable regulatory authority determines that—

4 (i) the class is one for which the per-  
5 son does not reject, and never has rejected,  
6 small employers included within the defini-  
7 tion of employers eligible for the class of  
8 business or otherwise eligible employees  
9 and dependents who enroll on a timely  
10 basis, based upon their claims experience,  
11 health status, industry, or occupation,

12 (ii) the person does not transfer, and  
13 never has transferred, an accident and  
14 health insurance contract involuntarily into  
15 or out of the class of business, and

16 (iii) accident and health insurance  
17 contracts offered under the class of busi-  
18 ness are currently available for purchase  
19 by small employers at the time an excep-  
20 tion to subparagraph (A) is sought by the  
21 person.

22 (2) LIMIT ON VARIATION IN PREMIUM RATES  
23 WITHIN A CLASS OF BUSINESS.—For a class of busi-  
24 ness of a person issuing an accident and health in-  
25 surance contract to a small employer, the highest

1 premium rates charged during a rating period to  
2 small employers with similar demographic character-  
3 istics (including age, sex, and geography and not re-  
4 lating to claims experience, health status, industry,  
5 occupation, or duration of coverage since issue) for  
6 the same or similar coverage, or the highest rates  
7 which could be charged to such employers under the  
8 rating system for that class of business, shall not ex-  
9 ceed an amount that is 1.5 times the base premium  
10 rate for the class of business for a rating period (or  
11 portion thereof) that occurs in the first 3 years in  
12 which this subsection is in effect, and 1.35 times the  
13 base premium rate thereafter.

14 (3) CONSISTENT APPLICATION OF RATING FAC-  
15 TORS.—In establishing premium rates for any acci-  
16 dent and health insurance contract offered to small  
17 employers—

18 (A) the person making adjustments with  
19 respect to age, sex, or geography must apply  
20 such adjustments consistently across small em-  
21 ployers, and

22 (B) no person may use a geographic area  
23 that is smaller than a county or smaller than  
24 an area that includes all areas in which the



1 first three digits of the zip code are identical,  
2 whichever is smaller.

3 (4) LIMIT ON TRANSFER OF EMPLOYERS  
4 AMONG CLASSES OF BUSINESS.—

5 (A) IN GENERAL.—A person issuing an ac-  
6 cident and health insurance contract to a small  
7 employer may not transfer a small employer  
8 from one class of business to another without  
9 the consent of the employer.

10 (B) OFFERS TO TRANSFER.—The person  
11 may not offer to transfer a small employer from  
12 one class of business to another unless—

13 (i) the offer is made without regard to  
14 age, sex, geography, claims experience,  
15 health status, industry, occupation or the  
16 date on which the policy was issued, and

17 (ii) the same offer is made to all other  
18 small employers in the same class of busi-  
19 ness.

20 (5) LIMITS ON VARIATION IN PREMIUM IN-  
21 CREASES.—The percentage increase in the premium  
22 rate charged to a small employer for a new rating  
23 period (determined on an annual basis) may not ex-  
24 ceed the sum of the percentage change in the base  
25 premium rate plus 5 percentage points.

1           (6) FULL DISCLOSURE OF RATING PRAC-  
2       TICES.—

3           (A) IN GENERAL.—At the time a person  
4       offers an accident and health insurance contract  
5       to a small employer, the person shall fully dis-  
6       close to the employer all of the following:

7           (i) Rating practices for small em-  
8       ployer accident and health insurance con-  
9       tracts, including rating practices for dif-  
10      ferent populations and benefit designs.

11          (ii) The extent to which premium  
12      rates for the small employer are based on  
13      risk characteristics and on factors other  
14      than risk characteristics.

15          (iii) The provisions concerning the  
16      person's right to change premium rates,  
17      the extent to which premiums can be modi-  
18      fied, and the factors which affect changes  
19      in premium rates.

20          (iv) The class of business within  
21      which the contract falls, including a de-  
22      scription of the grouping of contracts with-  
23      in a class of business.

24          (B) NOTICE ON EXPIRATION.—A person  
25      issuing accident and health insurance contracts

1 to small employers shall provide for notice, at  
2 least 60 days before the date of expiration of  
3 the accident and health insurance contract, of  
4 the terms for renewal of the contract. Such no-  
5 tice shall include an explanation of the extent to  
6 which any increase in premiums is due to actual  
7 or expected claims experience of the individuals  
8 covered under the small employer's accident  
9 and health insurance contract.

10 (7) ACTUARIAL CERTIFICATION.—Each person  
11 issuing an accident and health contract to a small  
12 employer shall file annually with the applicable regu-  
13 latory authority a written statement by a qualified  
14 health actuary (or other individual acceptable to  
15 such authority) that, based upon an examination by  
16 the individual which includes a review of the appro-  
17 priate records and of the actuarial assumptions of  
18 the person and methods used by the person in estab-  
19 lishing premium rates for small employer accident  
20 and health insurance contracts—

21 (A) the person is in compliance with the  
22 applicable provisions of this subsection, and

23 (B) the rating methods are actuarially  
24 sound.

1           (8) RECORDKEEPING.—Each person issuing an  
2       accident and health insurance contract to a small  
3       employer shall retain for examination at its principal  
4       place of business a complete and detailed description  
5       of its rating and renewal underwriting practices and  
6       the information on which such practices are based,  
7       including the statement described in paragraph (7).

8   **SEC. 104. STATE COMPLIANCE AGREEMENTS.**

9       (a) AGREEMENTS.—The Secretary may, in the dis-  
10      cretion of the Secretary, enter into an agreement with any  
11      State—

12           (1) to apply the standards set by the laws of  
13       such State for accident and health insurance con-  
14       tracts issued by any person to any small employer  
15       in lieu of the requirements of section 102, or

16           (2) to provide for the State to make the initial  
17       determination as to whether a person is in compli-  
18       ance with the provisions of section 102.

19       (b) STANDARDS.—An agreement may be entered into  
20      under subsection (a)(1) only if—

21           (1) the chief executive officer of the State re-  
22       quests such agreement be entered into,

23           (2) the Secretary determines that the State  
24       standards to be applied under the agreement will  
25       apply to substantially all accident and health insur-

1       ance contracts issued to small employers in such  
2       State, and

3               (3) the Secretary determines that the applica-  
4       tion of the State standards will carry out the pur-  
5       poses of section 102.

6       (c) LIMITATION ON WAIVER.—Any agreement en-  
7       tered into under subsection (a)(1) shall not waive the man-  
8       datory policy requirements under section 102(b).

9       (d) TERMINATION.—The Secretary shall terminate  
10      any agreement if the Secretary determines that the appli-  
11      cation of State standards ceases to carry out the purposes  
12      of this section.

13   **SEC. 105. DEFINITIONS AND OTHER RULES.**

14      For purposes of this subtitle:

15               (1) ACCIDENT AND HEALTH INSURANCE CON-  
16      TRACT.—

17                       (A) IN GENERAL.—The term “accident  
18                       and health insurance contract” means a con-  
19                       tract under which a person authorized under  
20                       applicable State insurance laws provides a  
21                       health insurance plan or arrangement to a  
22                       small employer. Such term does not include any  
23                       self-insured plan of an employer.

1 (B) CERTAIN CONTRACTS NOT COV-  
2 ERED.—The term “accident and health insur-  
3 ance contract” does not include any contract—

4 (i) which provides for accident only,  
5 dental only, or disability only coverage,

6 (ii) which provides coverage as a sup-  
7 plement to liability insurance,

8 (iii) which provides insurance arising  
9 out of a workmen’s compensation or simi-  
10 lar law, or automobile medical-payment in-  
11 surance, or

12 (iv) which provides insurance which is  
13 required by law to be contained under any  
14 self-insured plan of an employer.

15 (2) BASE PREMIUM RATE.—The term “base  
16 premium rate” means, for each class of business for  
17 each rating period, the lowest premium rate which  
18 could have been charged under a rating system for  
19 that class of business by the person issuing accident  
20 and health insurance contracts to small employers  
21 with similar demographic or other relevant charac-  
22 teristics (including age, sex, and geography and not  
23 relating to claims experience, health status, industry,  
24 occupation or duration of coverage since issue) for

1 accident and health insurance contracts with the  
2 same or similar coverage.

3 (3) CLASS OF BUSINESS.—

4 (A) IN GENERAL.—Except as provided in  
5 subparagraph (B), the term “class of business”  
6 means, with respect to a person, all of the small  
7 employers with an accident and health insur-  
8 ance contract issued by the person.

9 (B) DISTINCT GROUPS.—

10 (i) IN GENERAL.—Subject to clause  
11 (ii), a distinct group of small employers  
12 with accident and health insurance con-  
13 tracts issued by a person may be treated  
14 as a class of business by such person if all  
15 of the contracts in such group—

16 (I) are marketed and sold  
17 through individuals and organizations  
18 that do not participate in the market-  
19 ing or sale of other distinct groups by  
20 the person,

21 (II) have been acquired from an-  
22 other person as a distinct group, or

23 (III) are provided through an as-  
24 sociation with membership of not less  
25 than 25 small employers that has

1           been formed for purposes other than  
2           obtaining health insurance.

3           (ii) EXCEPTION ALLOWED.—Except  
4           as provided in subparagraph (C), a person  
5           may not establish more than one distinct  
6           group of small employers for each category  
7           specified in clause (i).

8           (C) SPECIAL RULE.—A person may estab-  
9           lish up to 2 groups under each category in sub-  
10          paragraph (A) or (B) to account for differences  
11          in characteristics (other than differences in con-  
12          tract benefits) of accident and health insurance  
13          contracts that are expected to produce substan-  
14          tial variation in health care costs.

15          (4) MANAGED HEALTH CARE ARRANGEMENT.—  
16          The term “managed health care arrangement”  
17          means an arrangement which integrates the financ-  
18          ing and delivery of health care services to covered in-  
19          dividuals by employing the following:

20                (A) Contracts with selected health care  
21                providers to furnish health care services to  
22                members.

23                (B) The adoption of explicit standards for  
24                the selection and recertification of providers.



1 (C) An explicit, formal program for ongoing  
2 quality assurance and utilization review.

3 (D) Significant financial incentives for  
4 members to use the providers and procedures  
5 associated with the arrangement.

6 (5) CHARACTERISTICS.—

7 (A) IN GENERAL.—The term “characteris-  
8 tics” means, with respect to any insurance rat-  
9 ing system, the factors used in determining  
10 rates.

11 (B) RISK CHARACTERISTICS.—The term  
12 “risk characteristics” means factors related to  
13 the health risks of individuals, including health  
14 status, prior claims experience, the duration  
15 since the date of issue of a health insurance  
16 plan or arrangement, industry, and occupation.

17 (C) GEOGRAPHIC FACTORS.—In applying  
18 geographic location as a characteristic, a person  
19 may not use for purposes of this subtitle areas  
20 smaller than Census Bureau designations of  
21 metropolitan statistical areas and  
22 nonmetropolitan statistical areas.

23 (6) ELIGIBLE EMPLOYEE.—The term “eligible  
24 employee” means, with respect to an employer, any  
25 employee who normally works at least 30 hours per

1 week for that employer. For purposes of this para-  
2 graph, the term “employee” includes a self-employed  
3 individual as defined in section 401(c)(1) of the In-  
4 ternal Revenue Code of 1986.

5 (7) PERSON.—The term “person” includes a li-  
6 censed insurance company, a prepaid hospital or  
7 medical service plan, a health maintenance organiza-  
8 tion, or in States which have distinct insurance li-  
9 censure requirements, a multiple employer welfare  
10 arrangement.

11 (8) QUALIFIED HEALTH ACTUARY.—The term  
12 “qualified health actuary” means a member of the  
13 American Academy of Actuaries who is qualified by  
14 reason of prior and continuing education and rel-  
15 evant experience to render the actuarial opinion.

16 (9) SECRETARY.—The term “Secretary” means  
17 the Secretary of Health and Human Services, or the  
18 delegate of the Secretary.

19 (10) SMALL EMPLOYER.—The term “small em-  
20 ployer” means, with respect to a calendar year, an  
21 employer who normally employs more than 1 but  
22 less than 51 eligible employees on a typical business  
23 day. For purposes of the preceding sentence, all em-  
24 ployers covered under the same health insurance

1 plan or arrangement covered by a contract shall be  
2 treated as 1 employer.

3 **SEC. 106. AMENDMENT TO THE INTERNAL REVENUE CODE**  
4 **OF 1986.**

5 (a) IN GENERAL.—Chapter 47 of the Internal Reve-  
6 nue Code of 1986 (relating to excise taxes on qualified  
7 pension, etc. plans) is amended by adding at the end  
8 thereof the following new section:

9 **“SEC. 5000A. FAILURE TO SATISFY CERTAIN STANDARDS**  
10 **FOR HEALTH INSURANCE.**

11 “(a) GENERAL RULE.—In the case of any person is-  
12 suing an accident and health insurance contract to a small  
13 employer, there is hereby imposed a tax on the failure of  
14 such person to meet at any time during any taxable year  
15 the applicable requirements of section 101 of the BasiCare  
16 Health Access and Cost Control Act. The Secretary of  
17 Health and Human Services shall determine whether any  
18 person meets the requirements of such section.

19 “(b) AMOUNT OF TAX.—

20 “(1) IN GENERAL.—The amount of tax imposed  
21 by subsection (a) by reason of 1 or more failures  
22 during a taxable year shall be equal to 35 percent  
23 of the gross premiums received during such taxable  
24 year with respect to all accident and health insur-

1       ance contracts issued to a small employer by the  
2       person on whom such tax is imposed.

3           “(2) GROSS PREMIUMS.—For purposes of para-  
4       graph (1), gross premiums shall include any consid-  
5       eration received with respect to any accident and  
6       health insurance contract.

7           “(3) CONTROLLED GROUPS.—For purposes of  
8       paragraph (1)—

9           “(A) CONTROLLED GROUP OF CORPORA-  
10       TIONS.—All corporations which are members of  
11       the same controlled group of corporations shall  
12       be treated as 1 person. For purposes of the pre-  
13       ceding sentence, the term ‘controlled group of  
14       corporations’ has the meaning given to such  
15       term by section 1563(a), except that—

16           “(i) ‘more than 50 percent’ shall be  
17       substituted for ‘at least 80 percent’ each  
18       place it appears in section 1563(a)(1), and

19           “(ii) the determination shall be made  
20       without regard to subsections (a)(4) and  
21       (e)(3)(C) of section 1563.

22           “(B) PARTNERSHIPS, PROPRIETORSHIPS,  
23       ETC., WHICH ARE UNDER COMMON CONTROL.—  
24       Under regulations prescribed by the Secretary,  
25       all trades or business (whether or not incor-

porated) which are under common control shall be treated as 1 person. The regulations prescribed under this subparagraph shall be based on principles similar to the principles which apply in the case of subparagraph (A).

“(c) LIMITATION ON TAX.—

“(1) TAX NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No tax shall be imposed by subsection (a) with respect to any failure for which it is established to the satisfaction of the Secretary that the person on whom the tax is imposed did not know, and exercising reasonable diligence would not have known, that such failure existed.

“(2) TAX NOT TO APPLY WHERE FAILURES CORRECTED WITHIN 30 DAYS.—No tax shall be imposed by subsection (a) with respect to any failure if—

“(A) such failure was due to reasonable cause and not to willful neglect, and

“(B) such failure is corrected during the 30-day period beginning on the first date any of the persons on whom the tax is imposed knew, or exercising reasonable diligence would have known, that such failure existed.

(b) NONDEDUCTIBILITY OF TAX.—Paragraph (6) of section 275(a) of such Code (relating to nondeductibility of certain taxes) is amended by inserting “47,” after “46,”.

“Sec. 5000A. Failure to satisfy certain standards for health insurance.”.

1           (2) NONDEDUCTIBILITY OF TAX.—The amend-  
 2           ment made by subsection (b) shall apply to taxable  
 3           years beginning after December 31, 1993.

4 **SEC. 107. EFFECTIVE DATE.**

5           (a) IN GENERAL.—Except as provided in section 106  
 6           and subsection (b), this subtitle shall apply to contracts  
 7           issued, or renewed, after the date of the enactment of this  
 8           Act and before the effective date of the legislation de-  
 9           scribed in section 212(a) or 213(a) of this Act.

10          (b) GUARANTEED ISSUE.—The provisions of section  
 11          102(c) shall apply to contracts which are issued, or re-  
 12          newed, after the date which is 12 months after the date  
 13          of the enactment of this Act and before the effective date  
 14          of the legislation described in section 212(a) or 213(a) of  
 15          this Act.

16               **Subtitle B—Community Health**  
 17               **Services Expansion**

18 **SEC. 111. ESTABLISHMENT OF GRANT PROGRAM.**

19          Subpart I of part D of title III of the Public Health  
 20          Service Act (42 U.S.C. 254b et seq.) is amended by adding  
 21          at the end thereof the following new section:

22 **“SEC. 330A. COMMUNITY-BASED PRIMARY HEALTH CARE**  
 23               **GRANT PROGRAM.**

24          “(a) ESTABLISHMENT.—The Secretary shall estab-  
 25          lish and administer a program to provide allotments to

1 States to enable such States to provide grants for the cre-  
2 ation or enhancement of community-based primary health  
3 care entities that provide services to low-income or medi-  
4 cally underserved populations.

5 “(b) ALLOTMENTS TO STATES.—

6 “(1) IN GENERAL.—From the amount available  
7 for allotment under subsection (h) for a fiscal year,  
8 the Secretary shall allot to each State an amount  
9 equal to the product of the grant share of the State  
10 (as determined under paragraph (2)) multiplied by  
11 such amount available.

12 “(2) GRANT SHARE.—

13 “(A) IN GENERAL.—For purposes of para-  
14 graph (1), the grant share of a State shall be  
15 the product of the need-adjusted population of  
16 the State (as determined under subparagraph  
17 (B)) multiplied by the Federal matching per-  
18 centage of the State (as determined under sub-  
19 paragraph (C)), expressed as a percentage of  
20 the sum of the products of such factors for all  
21 States.

22 “(B) NEED-ADJUSTED POPULATION.—

23 “(i) IN GENERAL.—For purposes of  
24 subparagraph (A), the need-adjusted popu-  
25 lation of a State shall be the product of



1 the total population of the State (as esti-  
2 mated by the Secretary of Commerce) mul-  
3 tiplied by the need index of the State (as  
4 determined under clause (ii)).

5 “(ii) NEED INDEX.—For purposes of  
6 clause (i), the need index of a State shall  
7 be the ratio of—

8 “(I) the weighted sum of the geo-  
9 graphic percentage of the State (as  
10 determined under clause (iii)), the  
11 poverty percentage of the State (as  
12 determined under clause (iv)), and the  
13 multiple grant percentage of the State  
14 (as determined under clause (v)); to

15 “(II) the general population per-  
16 centage of the State (as determined  
17 under clause (vi)).

18 “(iii) GEOGRAPHIC PERCENTAGE.—

19 “(I) IN GENERAL.—For purposes  
20 of clause (ii)(I), the geographic per-  
21 centage of the State shall be the esti-  
22 mated population of the State that is  
23 residing in nonurbanized areas (as de-  
24 termined under subclause (II)) ex-

1           pressed as a percentage of the total  
2           nonurbanized population of all States.

3           “(II)   NONURBANIZED   POPU-  
4           LATION.—For purposes of subclause  
5           (I), the estimated population of the  
6           State that is residing in nonurbanized  
7           areas shall be one minus the urban-  
8           ized population of the State (as deter-  
9           mined using the most recent decennial  
10          census), expressed as a percentage of  
11          the total population of the State (as  
12          determined using the most recent de-  
13          cennial census), multiplied by the cur-  
14          rent estimated population of the  
15          State.

16          “(iv)   POVERTY   PERCENTAGE.—For  
17          purposes of clause (ii)(I), the poverty per-  
18          centage of the State shall be the estimated  
19          number of people residing in the State  
20          with incomes below 200 percent of the in-  
21          come official poverty line (as determined  
22          by the Office of Management and Budget)  
23          expressed as a percentage of the total  
24          number of such people residing in all  
25          States.

1           “(v) MULTIPLE GRANT PERCENT-  
2           AGE.—For purposes of clause (ii)(I), the  
3           multiple grant percentage of the State  
4           shall be the amount of Federal funding re-  
5           ceived by the State under grants awarded  
6           under sections 329, 330, and 340, ex-  
7           pressed as a percentage of the total  
8           amounts received under such grants by all  
9           States. With respect to a State, such per-  
10          centage shall not exceed twice the general  
11          population percentage of the State under  
12          clause (vi) or be less than one-half of the  
13          States general population percentage.

14          “(vi) GENERAL POPULATION PER-  
15          CENTAGE.—For purposes of clause (ii)(II),  
16          the general population percentage of the  
17          State shall be the total population of the  
18          State (as determined by the Secretary of  
19          Commerce) expressed as a percentage of  
20          the total population of all States.

21          “(C) FEDERAL MATCHING PERCENTAGE.—

22          “(i) IN GENERAL.—For purposes of  
23          subparagraph (A), the Federal matching  
24          percentage of the State shall be equal to

1 one, less the State matching percentage (as  
2 determined under clause (ii)).

3 “(ii) STATE MATCHING PERCENT-  
4 AGE.—For purposes of clause (i), the State  
5 matching percentage of the State shall be  
6 0.25 multiplied by the ratio of the total  
7 taxable resource percentage (as determined  
8 under clause (iii)) to the need-adjusted  
9 population of the State (as determined  
10 under subparagraph (B)).

11 “(iii) TOTAL TAXABLE RESOURCE  
12 PERCENTAGE.—For purposes of clause (ii),  
13 the total taxable resources percentage of  
14 the State shall be the total taxable re-  
15 sources of a State (as determined by the  
16 Secretary of the Treasury) expressed as a  
17 percentage of the sum of the total taxable  
18 resources of all States.

19 “(3) ANNUAL ESTIMATES.—

20 “(A) IN GENERAL.—If the Secretary of  
21 Commerce does not produce the annual esti-  
22 mates required under paragraph (2)(B)(iv),  
23 such estimates shall be determined by multiply-  
24 ing the percentage of the population of the  
25 State that is below 200 percent of the income

1 official poverty line as determined using the  
2 most recent decennial census by the most recent  
3 estimate of the total population of the State.  
4 Except as provided in subparagraph (B), the  
5 calculations required under this subparagraph  
6 shall be made based on the most recent 3-year  
7 average of the total taxable resources of individ-  
8 uals within the State.

9 “(B) DISTRICT OF COLUMBIA.—Notwith-  
10 standing subparagraph (A), the calculations re-  
11 quired under such subparagraph with respect to  
12 the District of Columbia shall be based on the  
13 most recent 3-year average of the personal in-  
14 come of individuals residing within the District  
15 as a percentage of the personal income for all  
16 individuals residing within the District, as de-  
17 termined by the Secretary of Commerce.

18 “(4) MATCHING REQUIREMENT.—A State that  
19 receives an allotment under this section shall make  
20 available State resources (either directly or indi-  
21 rectly) to carry out this section in an amount that  
22 shall equal the State matching percentage for the  
23 State (as determined under paragraph (2)(C)(ii)) di-  
24 vided by the Federal matching percentage (as deter-  
25 mined under paragraph (2)(C)).

1 “(c) APPLICATION.—

2 “(1) IN GENERAL.—To be eligible to receive an  
3 allotment under this section, a State shall prepare  
4 and submit an application to the Secretary at such  
5 time, in such manner, and containing such informa-  
6 tion as the Secretary may by regulation require.

7 “(2) ASSURANCES.—A State application sub-  
8 mitted under paragraph (1) shall contain an assur-  
9 ance that—

10 “(A) the State will use amounts received  
11 under its allotment consistent with the require-  
12 ments of this section; and

13 “(B) the State will provide, from non-Fed-  
14 eral sources, the amounts required under sub-  
15 section (b)(4).

16 “(d) USE OF FUNDS.—

17 “(1) IN GENERAL.—The State shall use  
18 amounts received under this section to award grants  
19 to eligible public and nonprofit private entities, or  
20 consortia of such entities, within the State to enable  
21 such entities or consortia to provide services of the  
22 type described in paragraph (2) of section 329(h) to  
23 low-income or medically underserved populations.

1           “(2) ELIGIBILITY.—To be eligible to receive a  
2       grant under paragraph (1), an entity or consortium  
3       shall—

4           “(A) prepare and submit to the admin-  
5       istering entity of the State, an application at  
6       such time, in such manner, and containing such  
7       information as such administering entity may  
8       require, including a plan for the provision of  
9       services of the type described in paragraph (3);

10          “(B) provide assurances that services will  
11       be provided under the grant at fee rates estab-  
12       lished or determined in accordance with section  
13       330(e)(3)(F); and

14          “(C) provide assurances that in the case of  
15       services provided to individuals with health in-  
16       surance, such insurance shall be used as the  
17       primary source of payment for such services.

18          “(3) SERVICES.—The services to be provided  
19       under a grant awarded under paragraph (1) shall in-  
20       clude—

21          “(A) one or more of the types of primary  
22       health services described in section 330(b)(1);

23          “(B) one or more of the types of supple-  
24       mental health services described in section  
25       330(b)(2); and

1           “(C) any other services determined appro-  
2           priate by the administering entity of the State.

3           “(4) TARGET POPULATIONS.—Entities or con-  
4           sortia receiving grants under paragraph (1) shall, in  
5           providing the services described in paragraph (3),  
6           substantially target populations of low-income or  
7           medically underserved populations within the State  
8           who reside in medically underserved or health pro-  
9           fessional shortage areas, areas certified as under-  
10          served under the rural health clinic program, or  
11          other areas determined appropriate by the admin-  
12          istering entity of the State, within the State.

13          “(5) PRIORITY.—In awarding grants under  
14          paragraph (1), the State shall—

15               “(A) give priority to entities or consortia  
16               that can demonstrate through the plan submit-  
17               ted under paragraph (2) that—

18                       “(i) the services provided under the  
19                       grant will expand the availability of pri-  
20                       mary care services to the maximum num-  
21                       ber of low-income or medically underserved  
22                       populations who have no access to such  
23                       care on the date of the grant award; and

24                       “(ii) the delivery of services under the  
25                       grant will be cost-effective; and



1           “(B) ensure that an equitable distribution  
2           of funds is achieved among urban and rural en-  
3           tities or consortia.

4           “(e) REPORTS AND AUDITS.—Each State shall pre-  
5           pare and submit to the Secretary annual reports concern-  
6           ing the State’s activities under this section which shall be  
7           in such form and contain such information as the Sec-  
8           retary determines appropriate. Each such State shall es-  
9           tablish fiscal control and fund accounting procedures as  
10          may be necessary to assure that amounts received under  
11          this section are being disbursed properly and are ac-  
12          counted for, and include the results of audits conducted  
13          under such procedures in the reports submitted under this  
14          subsection.

15          “(f) PAYMENTS.—

16               “(1) ENTITLEMENT.—Each State for which an  
17               application has been approved by the Secretary  
18               under this section shall be entitled to payments  
19               under this section for each fiscal year in an amount  
20               not to exceed the State’s allotment under subsection  
21               (b) to be expended by the State in accordance with  
22               the terms of the application for the fiscal year for  
23               which the allotment is to be made.

24               “(2) METHOD OF PAYMENTS.—The Secretary  
25               may make payments to a State in installments, and

1 in advance or by way of reimbursement, with nec-  
2 essary adjustments on account of overpayments or  
3 underpayments, as the Secretary may determine.

4 “(3) STATE SPENDING OF PAYMENTS.—Pay-  
5 ments to a State from the allotment under sub-  
6 section (b) for any fiscal year must be expended by  
7 the State in that fiscal year or in the succeeding fis-  
8 cal year.

9 “(g) DEFINITION.—As used in this section, the term  
10 ‘administering entity of the State’ means the agency or  
11 official designated by the chief executive officer of the  
12 State to administer the amounts provided to the State  
13 under this section.

14 “(h) FUNDING.—Notwithstanding any other provi-  
15 sion of law, the Secretary shall use 50 percent of the  
16 amounts that the Secretary is required to utilize under  
17 section 330B(h) in each fiscal year to carry out this sec-  
18 tion.”.

19 **SEC. 112. PROGRAM TO PROVIDE FOR EXPANSION OF FED-**  
20 **ERALLY QUALIFIED HEALTH CENTERS.**

21 (a) IN GENERAL.—Subpart I of part D of title III  
22 of the Public Health Service Act (42 U.S.C. 254b et seq.)  
23 (as amended by section 111) is further amended by adding  
24 at the end thereof the following new section:

1 **“SEC. 330B. PROGRAM TO PROVIDE FOR EXPANSION OF**  
2 **FEDERALLY QUALIFIED HEALTH CENTERS.**

3 “(a) ESTABLISHMENT OF HEALTH SERVICES AC-  
4 CESS PROGRAM.—From amounts appropriated under this  
5 section, the Secretary shall, acting through the Bureau of  
6 Health Care Delivery Assistance, award grants under this  
7 section to federally qualified health centers (hereafter re-  
8 ferred to in this section as ‘FQHCs’) and other entities  
9 and organizations submitting applications under this sec-  
10 tion (as described in subsection (c)) for the purpose of  
11 providing access to services for medically underserved pop-  
12 ulations (as defined in section 330(b)(3)) or in high im-  
13 pact areas (as defined in section 329(a)(5)) not currently  
14 being served by a FQHC.

15 “(b) ELIGIBILITY FOR GRANTS.—

16 “(1) IN GENERAL.—The Secretary shall award  
17 grants under this section to entities or organizations  
18 described in this paragraph and paragraph (2) which  
19 have submitted a proposal to the Secretary to ex-  
20 pand such entities or organizations operations (in-  
21 cluding expansions to new sites (as determined nec-  
22 essary by the Secretary)) to serve medically under-  
23 served populations or high impact areas not cur-  
24 rently served by a FQHC and which—

25 “(A) have as of the date of enactment of  
26 the BasiCare Health Access and Cost Control

1 Act, been certified by the Secretary as a FQHC  
2 under section 1905(l)(2)(B) of the Social Secu-  
3 rity Act;

4 “(B) have submitted applications to the  
5 Secretary to qualify as FQHCs under section  
6 1905(l)(2)(B) of the Social Security Act; or

7 “(C) have submitted a plan to the Sec-  
8 retary which provides that the entity or organi-  
9 zation will meet the requirements to qualify as  
10 a FQHC when operational.

11 “(2) NON-FQHC ENTITIES.—

12 “(A) ELIGIBILITY.—The Secretary shall  
13 also make grants under this section to any pub-  
14 lic or private nonprofit agency, or any health  
15 care entity or organization which—

16 “(i) meets the requirements necessary  
17 to qualify as a FQHC, except the require-  
18 ment that such agency, entity, or organiza-  
19 tion has a consumer majority governing  
20 board,

21 “(ii) has submitted a proposal to the  
22 Secretary to provide those services pro-  
23 vided by a FQHC as defined in section  
24 1905(l)(2)(B) of the Social Security Act,  
25 and

1           “(iii) is designed to promote access to  
2           primary care services or to reduce reliance  
3           on hospital emergency rooms or other high  
4           cost providers of primary health care serv-  
5           ices,

6           provided that the proposal described in clause  
7           (ii) is developed by the agency, entity, or orga-  
8           nization (or such agencies, entities, or organiza-  
9           tions acting in a consortium in a community)  
10          with the review and approval of the Governor of  
11          the State in which such agency, entity, or orga-  
12          nization is located.

13          “(B) LIMITATION.—The Secretary shall  
14          provide in making grants to entities or organi-  
15          zations described in this paragraph that not  
16          more than 10 percent of the funds provided for  
17          grants under this section shall be made avail-  
18          able for grants to such entities or organizations.

19          “(c) APPLICATION REQUIREMENTS.—

20          “(1) IN GENERAL.—In order to be eligible to  
21          receive a grant under this section, a FQHC or other  
22          entity or organization must submit an application in  
23          such form and at such time as the Secretary shall  
24          prescribe and which meets the requirements of this  
25          subsection.

1           “(2) REQUIREMENTS.—An application submit-  
2       ted under this section must provide—

3           “(A)(i) for a schedule of fees or payments  
4       for the provision of the services provided by the  
5       entity or organization designed to cover its rea-  
6       sonable costs of operations; and

7           “(ii) for a corresponding schedule of dis-  
8       counts to be applied to such fees or payments,  
9       based upon the patient’s ability to pay (deter-  
10      mined by using a sliding scale formula based on  
11      the income of the patient);

12          “(B) assurances that the entity or organi-  
13      zation provides services to persons who are eli-  
14      gible for benefits under title XVIII of the Social  
15      Security Act, for medical assistance under title  
16      XIX of such Act, or for assistance for medical  
17      expenses under any other public assistance pro-  
18      gram or private health insurance program; and

19          “(C) assurances that the entity or organi-  
20      zation has made and will continue to make  
21      every reasonable effort to collect reimbursement  
22      for services—

23           “(i) from persons eligible for assist-  
24          ance under any of the programs described  
25          in subparagraph (B); and

1 “(ii) from patients not entitled to ben-  
2 efits under any such programs.

3 “(d) LIMITATIONS ON USE OF FUNDS.—

4 “(1) IN GENERAL.—From the amounts award-  
5 ed to a FQHC or other entity or organization under  
6 this section, funds may be used for purposes of plan-  
7 ning but may only be expended for the costs of—

8 “(A) assessing the needs of the populations  
9 or proposed areas to be served;

10 “(B) preparing a description of how the  
11 needs identified will be met; and

12 “(C) development of an implementation  
13 plan that addresses—

14 “(i) recruitment and training of per-  
15 sonnel; and

16 “(ii) activities necessary to achieve  
17 operational status in order to meet FQHC  
18 requirements under 1905(l)(2)(B) of the  
19 Social Security Act.

20 “(2) RECRUITING, TRAINING, AND COMPENSA-  
21 TION OF STAFF.—From the amounts awarded to an  
22 entity or organization under this section, funds may  
23 be used for the purposes of paying for the costs of  
24 recruiting, training, and compensating staff (clinical  
25 and associated administrative personnel (to the ex-

1       tent such costs are not already reimbursed under  
2       title XIX of the Social Security Act or any other  
3       State or Federal program)) to the extent necessary  
4       to allow the entity or organization to operate at new  
5       or expanded existing sites.

6               “(3) FACILITIES AND EQUIPMENT.—From the  
7       amounts awarded to an entity or organization under  
8       this section, funds may be expended for the purposes  
9       of acquiring facilities and equipment but only for the  
10       costs of—

11               “(A) construction of new buildings (to the  
12       extent that new construction is found to be the  
13       most cost-efficient approach by the Secretary);

14               “(B) acquiring, expanding, or modernizing  
15       existing facilities;

16               “(C) purchasing essential (as determined  
17       by the Secretary) equipment; and

18               “(D) amortization of principal and pay-  
19       ment of interest on loans obtained for purposes  
20       of site construction, acquisition, modernization,  
21       or expansion, as well as necessary equipment.

22               “(4) SERVICES.—From the amounts awarded  
23       to an entity or organization under this section, funds  
24       may be expended for the payment of services but  
25       only for the costs of—



1           “(A) providing or arranging for the provi-  
2           sion of all services through the entity or organi-  
3           zation necessary to qualify such entity or orga-  
4           nization as a FQHC under section  
5           1905(l)(2)(B) of the Social Security Act;

6           “(B) providing or arranging for any other  
7           service that a FQHC may provide and be reim-  
8           bursed for under title XIX of the Social Secu-  
9           rity Act; and

10           “(C) providing any unreimbursed costs of  
11           providing services as described in section 330(a)  
12           to patients.

13           “(e) PRIORITIES IN THE AWARDING OF GRANTS.—

14           “(1) CERTIFIED FQHCs.—The Secretary shall  
15           give priority in awarding grants under this section  
16           to entities and organizations which have, as of the  
17           date of enactment of the BasiCare Health Access  
18           and Cost Control Act, been certified as a FQHC  
19           under section 1905(l)(2)(B) of the Social Security  
20           Act and which have submitted a proposal to the Sec-  
21           retary to expand their operations (including expan-  
22           sion to new sites) to serve medically underserved  
23           populations for high impact areas not currently  
24           served by a FQHC. The Secretary shall give first  
25           priority in awarding grants under this section to

1       those FQHCs or other entities or organizations  
2       which propose to serve populations with the highest  
3       degree of unmet need, and which can demonstrate  
4       the ability to expand their operations in the most ef-  
5       ficient manner.

6           “(2) QUALIFIED FQHCs.—The Secretary shall  
7       give second priority in awarding grants to entities  
8       and organizations which have submitted applications  
9       to the Secretary which demonstrate that the entities  
10      or organizations will qualify as FQHCs under sec-  
11      tion 1905(l)(2)(B) of the Social Security Act before  
12      they provide or arrange for the provision of services  
13      supported by funds awarded under this section, and  
14      which are serving or proposing to serve medically  
15      underserved populations or high impact areas which  
16      are not currently served (or proposed to be served)  
17      by a FQHC.

18          “(3) EXPANDED SERVICES AND PROJECTS.—  
19      The Secretary shall give third priority in awarding  
20      grants in subsequent years to those FQHCs or other  
21      entities or organizations which have provided for ex-  
22      panded services and projects and are able to dem-  
23      onstrate that such entities or organizations will  
24      incur significant unreimbursed costs in providing  
25      such expanded services.

1       “(f) RETURN OF FUNDS TO SECRETARY FOR COSTS  
2 REIMBURSED FROM OTHER SOURCES.—To the extent  
3 that a FQHC or other entity or organization receiving  
4 funds under this section is reimbursed from another  
5 source for the provision of services to an individual, and  
6 does not use such increased reimbursement to expand  
7 services furnished, to expand areas served, to compensate  
8 for costs of unreimbursed services provided to patients, or  
9 to promote recruitment, training, or retention of person-  
10 nel, such excess revenues shall be returned to the Sec-  
11 retary.

12       “(g) TERMINATION OF GRANTS.—

13               “(1) FAILURE TO MEET FQHC REQUIRE-  
14 MENTS.—

15               “(A) IN GENERAL.—With respect to any  
16 entity or organization that is receiving funds  
17 awarded under this section and which subse-  
18 quently fails to meet the requirements to qual-  
19 ify as a FQHC under section 1905(l)(2)(B) of  
20 the Social Security Act or is an entity or orga-  
21 nization that is not required to meet the re-  
22 quirements to qualify as a FQHC under section  
23 1905(l)(2)(B) of the Social Security Act but  
24 fails to meet the requirements of this section,  
25 the Secretary shall terminate the award of

1 funds under this section to such entity or orga-  
2 nization.

3 “(B) NOTICE.—Prior to any termination  
4 of funds under this section to an entity or orga-  
5 nization, the entity or organization shall be en-  
6 titled to 60 days’ prior notice of termination  
7 and, as provided by the Secretary in regula-  
8 tions, an opportunity to correct any deficiencies  
9 in order to allow the entity or organization to  
10 continue to receive funds under this section.

11 “(2) REQUIREMENTS.—Upon any termination  
12 of funding under this section, the Secretary may (to  
13 the extent practicable)—

14 “(A) sell any property (including equip-  
15 ment) acquired or constructed by the entity or  
16 organization using funds made available under  
17 this section or transfer such property to an-  
18 other FQHC, except that the Secretary shall re-  
19 imburse any costs which were incurred by the  
20 entity or organization in acquiring or construct-  
21 ing such property (including equipment) which  
22 were not supported by grants under this sec-  
23 tion; and

1           “(B) recoup any funds provided to an en-  
 2           tity or organization terminated under this sec-  
 3           tion.

4           “(h) AUTHORIZATION OF APPROPRIATIONS.—There  
 5           are authorized to be appropriated to carry out this section  
 6           \$600,000,000 for each of the fiscal years 1994 through  
 7           1998.”.

8           (b) EFFECTIVE DATE.—The amendments made by  
 9           subsection (a) shall become effective with respect to serv-  
 10          ices furnished by a federally qualified health center or  
 11          other qualifying entity or organization described in this  
 12          section beginning on or after the date of enactment of this  
 13          Act.

14       **Subtitle C—Expansion of Tax In-**  
 15       **centives for Self-Employed Indi-**  
 16       **viduals**

17       **SEC. 121. PERMANENT INCREASE IN DEDUCTIBLE HEALTH**  
 18                       **INSURANCE COSTS FOR SELF-EMPLOYED IN-**  
 19                       **DIVIDUALS.**

20          (a) IN GENERAL.—Paragraph (1) of section 162(l)  
 21          of the Internal Revenue Code of 1986 (relating to special  
 22          rules for health insurance costs of self-employed individ-  
 23          uals) is amended by striking “25 percent” and inserting  
 24          “100 percent”.

1 (b) PERMANENT DEDUCTION.—Section 162(l) of  
 2 such Code is amended by striking paragraph (6).

3 (c) EFFECTIVE DATE.—The amendment made by  
 4 this subsection shall apply to taxable years beginning after  
 5 the date of enactment of this Act.

6 **Subtitle D—Expanding the Supply**  
 7 **of Health Professionals in Rural**  
 8 **Areas**

9 **SEC. 131. EXPANSION OF NATIONAL HEALTH SERVICE**  
 10 **CORPS.**

11 Section 338H(b) of the Public Health Service Act (42  
 12 U.S.C. 254q(b)) is amended—

13 (1) in paragraph (1), by striking “and such  
 14 sums” and all that follows through the end thereof  
 15 and inserting “\$120,000,000 for each of the fiscal  
 16 years 1992 through 1997.”; and

17 (2) in paragraph (2)—

18 (A) by redesignating subparagraphs (A)  
 19 and (B) as subparagraphs (B) and (C), respec-  
 20 tively; and

21 (B) by inserting before subparagraph (B)  
 22 (as so redesignated) the following new subpara-  
 23 graph:

24 “(A) IN GENERAL.—Of the amount appro-  
 25 priated under paragraph (1) for each fiscal

1           year, the Secretary shall utilize 25 percent of  
 2           such amount to carry out section 338A and 75  
 3           percent of such amount to carry out section  
 4           338B.”.

5   **SEC. 132. TAX INCENTIVES FOR PRACTICE IN RURAL**  
 6                           **AREAS.**

7           (a) NONREFUNDABLE CREDIT FOR CERTAIN PRI-  
 8   MARY HEALTH SERVICES PROVIDERS.—

9                   (1) IN GENERAL.—Subpart A of part IV of sub-  
 10       chapter A of chapter 1 of the Internal Revenue Code  
 11       of 1986 (relating to nonrefundable personal credits)  
 12       is amended by inserting after section 25 the follow-  
 13       ing new section:

14   **“SEC. 25A. PRIMARY HEALTH SERVICES PROVIDERS.**

15       “(a) ALLOWANCE OF CREDIT.—In the case of a  
 16       qualified primary health services provider, there is allowed  
 17       as a credit against the tax imposed by this chapter for  
 18       any taxable year in a mandatory service period an amount  
 19       equal to the product of—

20                   “(1) the lesser of—

21                           “(A) the number of months of such period  
 22                       occurring in such taxable year, or

23                           “(B) 36 months, reduced by the number of  
 24                       months taken into account under this para-  
 25                       graph with respect to such provider for all pre-

1 ceding taxable years (whether or not in the  
2 same mandatory service period), multiplied by

3 “(2) \$1,000 (\$500 in the case of a qualified  
4 primary health services provider who is a physician  
5 assistant or a nurse practitioner).

6 “(b) QUALIFIED PRIMARY HEALTH SERVICES PRO-  
7 VIDER.—For purposes of this section, the term ‘qualified  
8 primary health services provider’ means any physician,  
9 physician assistant, or nurse practitioner who for any  
10 month during a mandatory service period is certified by  
11 the Bureau to be a primary health services provider who—

12 “(1) is providing primary health services—

13 “(A) full time, and

14 “(B) to individuals at least 80 percent of  
15 whom reside in a rural health professional  
16 shortage area,

17 “(2) is not receiving during such year a scholar-  
18 ship under the National Health Service Corps Schol-  
19 arship Program or a loan repayment under the Na-  
20 tional Health Service Corps Loan Repayment Pro-  
21 gram,

22 “(3) is not fulfilling service obligations under  
23 such Programs, and

24 “(4) has not defaulted on such obligations.



1       “(c) MANDATORY SERVICE PERIOD.—For purposes  
2 of this section, the term ‘mandatory service period’ means  
3 the period of 60 consecutive calendar months beginning  
4 with the first month the taxpayer is a qualified primary  
5 health services provider.

6       “(d) DEFINITIONS AND SPECIAL RULES.—For pur-  
7 poses of this section—

8               “(1) BUREAU.—The term ‘Bureau’ means the  
9 Bureau of Health Care Delivery and Assistance,  
10 Health Resources and Services Administration of the  
11 United States Public Health Service.

12              “(2) PHYSICIAN.—The term ‘physician’ has the  
13 meaning given to such term by section 1861(r) of  
14 the Social Security Act.

15              “(3) PHYSICIAN ASSISTANT; NURSE PRACTI-  
16 TIONER.—The terms ‘physician assistant’ and ‘nurse  
17 practitioner’ have the meanings given to such terms  
18 by section 1861(aa)(3) of the Social Security Act.

19              “(4) PRIMARY HEALTH SERVICES PROVIDER.—  
20 The term ‘primary health services provider’ means a  
21 provider of primary health services (as defined in  
22 section 330(b)(1) of the Public Health Service Act).

23              “(5) RURAL HEALTH PROFESSIONAL SHORTAGE  
24 AREA.—The term ‘rural health professional shortage  
25 area’ means—

1           “(A) a class 1 or class 2 rural health pro-  
2           fessional shortage area (as defined in section  
3           332(a)(1)(A) of the Public Health Service Act)  
4           in a rural area (as determined under section  
5           1886(d)(2)(D) of the Social Security Act), or

6           “(B) an area which is determined by the  
7           Secretary of Health and Human Services as  
8           equivalent to an area described in subparagraph  
9           (A) and which is designated by the Bureau of  
10          the Census as not urbanized.

11          “(C) a community that is certified as un-  
12          derserved by the Secretary for purposes of par-  
13          ticipation in the rural health clinic program  
14          under title XVIII of the Social Security Act.

15          “(e) RECAPTURE OF CREDIT.—

16               “(1) IN GENERAL.—If, during any taxable year,  
17          there is a recapture event, then the tax of the tax-  
18          payer under this chapter for such taxable year shall  
19          be increased by an amount equal to the product of—

20                       “(A) the applicable percentage, and

21                       “(B) the aggregate unrecaptured credits  
22          allowed to such taxpayer under this section for  
23          all prior taxable years.

24          “(2) APPLICABLE RECAPTURE PERCENTAGE.—

“(A) IN GENERAL.—For purposes of this subsection, the applicable recapture percentage shall be determined from the following table:

| <b>“If the recapture event occurs during:</b> | <b>The applicable recapture percentage is:</b> |
|---|--|
| Months 1–24 .....                             | 100  |
| Months 25–36 .....                            | 75   |
| Months 37–48 .....                            | 50   |
| Months 49–60 .....                            | 25   |
| Months 61 and thereafter .....                | 0.   |

“(B) TIMING.—For purposes of subparagraph (A), month 1 shall begin on the first day of the mandatory service period.

“(3) RECAPTURE EVENT DEFINED.—

“(A) IN GENERAL.—For purposes of this subsection, the term ‘recapture event’ means the failure of the taxpayer to be a qualified primary health services provider for any month during any mandatory service period.

“(B) CESSATION OF DESIGNATION.—The cessation of the designation of any area as a rural health professional shortage area after the beginning of the mandatory service period for any taxpayer shall not constitute a recapture event.

“(C) SECRETARIAL WAIVER.—The Secretary may waive any recapture event caused by extraordinary circumstances.

1           “(4) NO CREDITS AGAINST TAX.—Any increase  
 2           in tax under this subsection shall not be treated as  
 3           a tax imposed by this chapter for purposes of deter-  
 4           mining the amount of any credit under subpart A,  
 5           B, or D of this part.”.

6           (2) CLERICAL AMENDMENT.—The table of sec-  
 7           tions for subpart A of part IV of subchapter A of  
 8           chapter 1 of such Code is amended by inserting  
 9           after the item relating to section 25 the following  
 10          new item:

          “Sec. 25A. Primary health services providers.”.

11          (3) EFFECTIVE DATE.—The amendments made  
 12          by this subsection shall apply to taxable years begin-  
 13          ning after the date of the enactment of this Act.

14          (b) NATIONAL HEALTH SERVICE CORPS LOAN RE-  
 15          PAYMENTS EXCLUDED FROM GROSS INCOME.—

16               (1) IN GENERAL.—Part III of subchapter B of  
 17          chapter 1 of the Internal Revenue Code of 1986 (re-  
 18          lating to items specifically excluded from gross in-  
 19          come) is amended by redesignating section 136 as  
 20          section 137 and by inserting after section 135 the  
 21          following new section:

22       **“SEC. 136. NATIONAL HEALTH SERVICE CORPS LOAN RE-**  
 23       **PAYMENTS.**

24               “(a) GENERAL RULE.—Gross income shall not in-  
 25          clude any qualified loan repayment.

1       “(b) QUALIFIED LOAN REPAYMENT.—For purposes  
2 of this section, the term ‘qualified loan repayment’ means  
3 any payment made on behalf of the taxpayer by the Na-  
4 tional Health Service Corps Loan Repayment Program  
5 under section 338B(g) of the Public Health Service Act.”.

6           (2) CONFORMING AMENDMENT.—Paragraph (3)  
7 of section 338B(g) of the Public Health Service Act  
8 is amended by striking “Federal, State, or local”  
9 and inserting “State or local”.

10          (3) CLERICAL AMENDMENT.—The table of sec-  
11 tions for part III of subchapter B of chapter 1 of  
12 the Internal Revenue Code of 1986 is amended by  
13 striking the item relating to section 136 and insert-  
14 ing the following:

“Sec. 136. National Health Service Corps loan repayments.  
“Sec. 137. Cross references to other Acts.”.

15          (4) EFFECTIVE DATE.—The amendments made  
16 by this subsection shall apply to payments made  
17 under section 338B(g) of the Public Health Service  
18 Act after the date of the enactment of this Act.

19          (c) EXPENSING OF MEDICAL EQUIPMENT.—

20           (1) IN GENERAL.—Section 179 of the Internal  
21 Revenue Code of 1986 (relating to election to ex-  
22 pense certain depreciable business assets) is amend-  
23 ed—

1 (A) by striking paragraph (1) of subsection  
2 (b) and inserting the following:

3 “(1) DOLLAR LIMITATION.—

4 “(A) GENERAL RULE.—The aggregate cost  
5 which may be taken into account under sub-  
6 section (a) for any taxable year shall not exceed  
7 \$10,000.

8 “(B) RURAL HEALTH CARE PROPERTY.—

9 In the case of rural health care property, the  
10 aggregate cost which may be taken into account  
11 under subsection (a) for any taxable year shall  
12 not exceed \$25,000, reduced by the amount  
13 otherwise taken into account under subsection  
14 (a) for such year.”; and

15 (B) by adding at the end of subsection (d)  
16 the following new paragraph:

17 “(11) RURAL HEALTH CARE PROPERTY.—For  
18 purposes of this section, the term ‘rural health care  
19 property’ means section 179 property used by a phy-  
20 sician (as defined in section 1861(r) of the Social  
21 Security Act) in the active conduct of such physi-  
22 cian’s full-time trade or business of providing pri-  
23 mary health services (as defined in section 330(b)(1)  
24 of the Public Health Service Act) in a rural health

1 professional shortage area (as defined in section  
2 25A(d)(5)).”.

3 (2) EFFECTIVE DATE.—The amendments made  
4 by this subsection shall apply to property placed in  
5 service in taxable years beginning after the date of  
6 enactment of this Act.

7 (d) DEDUCTION FOR STUDENT LOAN PAYMENTS BY  
8 MEDICAL PROFESSIONALS PRACTICING IN RURAL  
9 AREAS.—

10 (1) INTEREST ON STUDENT LOANS NOT TREAT-  
11 ED AS PERSONAL INTEREST.—Section 163(h)(2) of  
12 the Internal Revenue Code of 1986 (defining per-  
13 sonal interest) is amended by striking “and” at the  
14 end of subparagraph (D), by striking the period at  
15 the end of subparagraph (E) and inserting “, and”,  
16 and by adding at the end thereof the following new  
17 subparagraph:

18 “(F) any qualified medical education interest  
19 (within the meaning of subsection (k)).”.

20 (2) QUALIFIED MEDICAL EDUCATION INTEREST  
21 DEFINED.—Section 163 of such Code (relating to in-  
22 terest expenses) is amended by redesignating sub-  
23 section (k) as subsection (l) and by inserting after  
24 subsection (j) the following new subsection:

1       “(k) QUALIFIED MEDICAL EDUCATION INTEREST OF  
2 MEDICAL PROFESSIONALS PRACTICING IN RURAL  
3 AREAS.—

4           “(1) IN GENERAL.—For purposes of subsection  
5 (h)(2)(F), the term ‘qualified medical education in-  
6 terest’ means an amount which bears the same ratio  
7 to the interest paid on qualified educational loans  
8 during the taxable year by an individual performing  
9 services under a qualified rural medical practice  
10 agreement as—

11           “(A) the number of months during the tax-  
12 able year during which such services were per-  
13 formed, bears to

14           “(B) the number of months in the taxable  
15 year.

16           “(2) DOLLAR LIMITATION.—The aggregate  
17 amount which may be treated as qualified medical  
18 education interest for any taxable year with respect  
19 to any individual shall not exceed \$5,000.

20           “(3) QUALIFIED RURAL MEDICAL PRACTICE  
21 AGREEMENT.—For purposes of this subsection—

22           “(A) IN GENERAL.—The term ‘qualified  
23 rural medical practice agreement’ means a writ-  
24 ten agreement between an individual and an ap-



1 applicable rural community under which the indi-  
2 vidual agrees—

3 “(i) in the case of a medical doctor,  
4 upon completion of the individual’s resi-  
5 dency (or internship if no residency is re-  
6 quired), or

7 “(ii) in the case of a registered nurse,  
8 nurse practitioner, or physician’s assistant,  
9 upon completion of the education to which  
10 the qualified education loan relates,

11 to perform full-time services as such a medical  
12 professional in the applicable rural community  
13 for a period of 24 consecutive months. An indi-  
14 vidual and an applicable rural community may  
15 elect to have the agreement apply for 36 con-  
16 secutive months rather than 24 months.

17 “(B) SPECIAL RULE FOR COMPUTING PE-  
18 RIODS.—An individual shall be treated as meet-  
19 ing the 24 or 36 consecutive month requirement  
20 under subparagraph (A) if, during each 12-con-  
21 secutive month period within either such period,  
22 the individual performs full-time services as a  
23 medical doctor, registered nurse, nurse practi-  
24 tioner, or physician’s assistant, whichever ap-  
25 plies, in the applicable rural community during

1 9 of the months in such 12-consecutive month  
2 period. For purposes of this subsection, an indi-  
3 vidual meeting the requirements of the preced-  
4 ing sentence shall be treated as performing  
5 services during the entire 12-month period.

6 “(C) APPLICABLE RURAL COMMUNITY.—

7 The term ‘applicable rural community’ means—

8 “(i) any political subdivision of a  
9 State which—

10 “(I) has a population of 5,000 or

11 less, and

12 “(II) has a per capita income of

13 \$15,000 or less, or

14 “(ii) an Indian reservation which has  
15 a per capita income of \$15,000 or less.

16 “(4) QUALIFIED EDUCATIONAL LOAN.—The

17 term ‘qualified educational loan’ means any indebt-  
18 edness to pay qualified tuition and related expenses  
19 (within the meaning of section 117(b)) and reason-  
20 able living expenses—

21 “(A) which are paid or incurred—

22 “(i) as a candidate for a degree as a  
23 medical doctor at an educational institu-  
24 tion described in section 170(b)(1)(A)(ii),  
25 or

1           “(ii) in connection with courses of in-  
2           struction at such an institution necessary  
3           for certification as a registered nurse,  
4           nurse practitioner, or physician’s assistant,  
5           and

6           “(B) which are paid or incurred within a  
7           reasonable time before or after such indebted-  
8           ness is incurred.

9           “(5) RECAPTURE.—If an individual fails to  
10          carry out a qualified rural medical practice agree-  
11          ment during any taxable year, then—

12               “(A) no deduction with respect to such  
13               agreement shall be allowable by reason of sub-  
14               section (h)(2)(F) for such taxable year and any  
15               subsequent taxable year, and

16               “(B) there shall be included in gross in-  
17               come for such taxable year the aggregate  
18               amount of the deductions allowable under this  
19               section (by reason of subsection (h)(2)(F)) for  
20               all preceding taxable years.

21           “(6) DEFINITIONS.—For purposes of this sub-  
22          section, the terms ‘registered nurse’, ‘nurse practi-  
23          tioner’, and ‘physician’s assistant’ have the meaning  
24          given such terms by section 1861 of the Social Secu-  
25          rity Act.”.

1           (3) DEDUCTION ALLOWED IN COMPUTING AD-  
 2 JUSTED GROSS INCOME.—Section 62(a) of such  
 3 Code is amended by inserting after paragraph (13)  
 4 the following new paragraph:

5           “(14) INTEREST ON STUDENT LOANS OF RURAL  
 6 HEALTH PROFESSIONALS.—The deduction allowable  
 7 by reason of section 163(h)(2)(F) (relating to stu-  
 8 dent loan payments of medical professionals practic-  
 9 ing in rural areas).”.

10           (4) EFFECTIVE DATE.—The amendments made  
 11 by this subsection shall apply to taxable years begin-  
 12 ning after the date of the enactment of this Act.

## 13       **Subtitle E—Malpractice Reform**

### 14           **PART I—DEFINITIONS**

#### 15       **SEC. 141. DEFINITIONS.**

16       For purposes of this subtitle:

17           (1) ALTERNATIVE DISPUTE RESOLUTION SYS-  
 18 TEM.—The term “alternative dispute resolution sys-  
 19 tem” means a system that is enacted or adopted by  
 20 a State to resolve health care liability actions as an  
 21 alternative to a judicial proceeding in a Federal or  
 22 State court.

23           (2) CONCERTED ACTION AND ACTING IN CON-  
 24 CERT.—The terms “concerted action” and “acting  
 25 in concert” mean the participation in joint conduct

1 by two or more persons who agree to jointly partici-  
2 pate in such conduct with actual knowledge of the  
3 wrongfulness of the conduct.

4 (3) ECONOMIC LOSSES.—The term “economic  
5 losses” means losses for health care provider and  
6 medical expenses, lost wages, lost employment, and  
7 other pecuniary losses.

8 (4) HEALTH CARE LIABILITY ACTION.—The  
9 term “health care liability action” means any civil  
10 action or proceeding in any judicial tribunal brought  
11 pursuant to Federal or State law against a health  
12 care provider alleging that injury was suffered by  
13 the claimant as a result of any act or omission by  
14 such provider, without regard to the theory of liabil-  
15 ity asserted in the action. Such term includes a  
16 claim, third-party claim, cross-claim, counter-claim,  
17 or contribution-claim.

18 (5) HEALTH CARE PROVIDER.—The term  
19 “health care provider” means—

20 (A) any individual who provides health  
21 care services in a State and who is required by  
22 State law or regulation to be licensed or cer-  
23 tified by the State to provide such services in  
24 the State; and

1 (B) any organization or institution that is  
2 engaged in the delivery of health care services  
3 in a State and that is required by State law or  
4 regulation to be licensed or certified by the  
5 State to engage in the delivery of such services  
6 in the State.

7 (6) INJURY.—The term “injury” means any in-  
8 jury, illness, disease, or other harm suffered by an  
9 individual as a result of the provision of health care  
10 services by a health care provider.

11 (7) NONECONOMIC LOSSES.—The term “non-  
12 economic losses” means losses for physical and emo-  
13 tional pain, suffering, physical impairment, mental  
14 anguish, disfigurement, loss of enjoyment of life, loss  
15 of companionship, consortium, and other  
16 nonpecuniary losses.

17 (8) SECRETARY.—The term “Secretary” means  
18 the Secretary of Health and Human Services.

19 (9) STATE.—The term “State” means each of  
20 the several States, the District of Columbia, the  
21 Commonwealth of Puerto Rico, the Virgin Islands,  
22 and Guam.

1       **PART II—TORT REFORM OF HEALTH CARE**

2                       **LIABILITY ACTIONS**

3   **SEC. 142. APPLICATION TO CIVIL ACTIONS.**

4       This part shall apply to any health care liability ac-  
5   tion brought in any Federal or State court. This part shall  
6   not be construed to create or effect any cause of action  
7   or theory of liability recognized in any Federal or State  
8   proceeding.

9   **SEC. 143. DAMAGES.**

10       (a) LIMITATION ON NONECONOMIC DAMAGES.—The  
11   total amount of damages which may be awarded to an in-  
12   dividual and the family members of such individual for  
13   noneconomic losses resulting from an injury which is the  
14   subject of a health care liability action may not exceed  
15   \$250,000, regardless of the number of health care provid-  
16   ers against whom such action is brought or the number  
17   of such actions brought with respect to the injury.

18       (b) PAYMENTS.—With respect to a health care liabil-  
19   ity action, no person may be required to pay more than  
20   \$100,000 in a single payment for an award of damages  
21   for economic or noneconomic losses, but such person shall  
22   be permitted to make such payments on a periodic basis.  
23   The periods for such payments shall be determined by the  
24   court.

25       (c) MANDATORY OFFSETS FOR DAMAGES PAID BY A  
26   COLLATERAL SOURCE.—

1           (1) IN GENERAL.—The total amount of dam-  
2       ages received by an individual in connection with a  
3       health care liability action shall be reduced, in ac-  
4       cordance with paragraph (2), by any other payment  
5       which has been made or which will be made to such  
6       individual to compensate such individual for an in-  
7       jury, including payments under—

8           (A) Federal or State disability or sickness  
9       programs;

10          (B) Federal, State, or private health insur-  
11       ance programs;

12          (C) private disability insurance programs;

13          (D) employer wage continuation programs;

14       and

15          (E) any other source of payment intended  
16       to compensate such individual for such injury.

17       (2) AMOUNT OF REDUCTION.—The amount by  
18       which an award of damages to an individual for an  
19       injury shall be reduced under paragraph (1) shall  
20       be—

21           (A) the total amount of any payments  
22       (other than such award) which have been made  
23       or which will be made to such individual to  
24       compensate such individual for such injury;  
25       minus



1 (B) the amount paid by such individual (or  
2 by the spouse, parent, or legal guardian of such  
3 individual) to secure the payments described in  
4 subparagraph (A).

5 (d) PUNITIVE DAMAGES.—

6 (1) LIMITATION.—With respect to a health care  
7 liability action, punitive damages may not exceed the  
8 sum of damages awarded for economic and non-  
9 economic losses.

10 (2) DETERMINATION OF AMOUNT.—In deter-  
11 mining the amount of punitive damages in a health  
12 care liability action, the trier of fact shall consider  
13 all relevant evidence, including—

14 (A) the severity of the harm caused by the  
15 conduct of the defendant;

16 (B) the duration of the conduct or any  
17 concealment of the conduct by the defendant;

18 (C) awards of punitive or exemplary dam-  
19 ages to persons similarly situated to the claim-  
20 ant; and

21 (D) prospective awards of economic and  
22 noneconomic losses to persons similarly situated  
23 to the claimant.

24 (e) ATTORNEYS' FEES.—Compensation for reason-  
25 able attorneys' fees to be paid by each party in connection

1 with a health care liability action shall be determined by  
2 the court after an evidentiary hearing and prior to final  
3 disposition of the action. Attorneys' fees shall be cal-  
4 culated on the basis of an hourly rate or as a percentage  
5 of the total damages awarded for economic and non-  
6 economic losses and shall not exceed an amount that  
7 would be considered reasonable based on the following:

8           (1) The time, labor, and skill necessary to prop-  
9       erly perform the legal services required by the ac-  
10      tion.

11          (2) The novelty and difficulty of the questions  
12      involved in the action.

13          (3) The likelihood, if apparent to the client,  
14      that the acceptance of employment with respect to  
15      the client's action will preclude other employment by  
16      the attorney.

17          (4) The fee customarily charged in the locality  
18      for similar legal services.

19          (5) The amount involved in the action and the  
20      results obtained.

21          (6) The time limitations imposed by the client  
22      or by the circumstances of the action.

23          (7) The nature and length of the professional  
24      relationship between the attorney or attorneys and  
25      the client.

1           (8) The experience, reputation, and ability of  
2           the attorney or attorneys performing the services in  
3           connection with the action.

4           (9) Whether the fee for services in connection  
5           with the action is fixed or contingent.

6   **SEC. 144. JOINT AND SEVERAL LIABILITY.**

7           (a) IN GENERAL.—With respect to a health care li-  
8           ability action, joint and several liability shall apply—

9                   (1) to the liability of each defendant for dam-  
10           ages for economic losses; and

11                   (2) as between persons acting in concert where  
12           the concerted action proximately caused the injury  
13           for which one or more persons are found liable for  
14           damages.

15           (b) NONECONOMIC DAMAGES.—With respect to a  
16           health care liability action, joint and several liability shall  
17           not apply to the liability of each defendant for damages  
18           for noneconomic losses. A person found liable for damages  
19           for noneconomic losses in any such action may—

20                   (1) be found liable, if at all, only for those dam-  
21           ages directly attributable to the pro rata share of  
22           fault or responsibility of such person for the injury;  
23           and

24                   (2) not be found liable for damages attributable  
25           to the pro rata share of fault or responsibility of any

1       other person (without regard to whether that person  
2       is a party to the action) for the injury, including any  
3       person bringing the action.

4   **SEC. 145. STATUTE OF LIMITATIONS.**

5       (a) IN GENERAL.—Except as provided in subsection  
6       (b), no health care liability action may be initiated after  
7       the expiration of the 2-year period that begins on the date  
8       on which the alleged injury should reasonably have been  
9       discovered, but in no event later than 4 years after the  
10      date of the alleged occurrence of the injury.

11      (b) EXCEPTION FOR MINORS.—In the case of an al-  
12      leged injury suffered by a minor who has not attained 6  
13      years of age, no health care liability action may be initi-  
14      ated after the expiration of the 2-year period that begins  
15      on the date on which the alleged injury should reasonably  
16      have been discovered, but in no event later than 4 years  
17      after the date of the alleged occurrence of the injury or  
18      the date on which the minor attains 8 years of age, which-  
19      ever is later.

20   **SEC. 146. PREEMPTION.**

21      (a) IN GENERAL.—This part supersedes any State  
22      law only to the extent that State law establishes higher  
23      payment limits, permits the recovery of a greater amount  
24      of damages or the awarding of a greater amount of attor-

1 neys' fees, or establishes a longer period during which a  
2 health care liability action may be initiated.

3 (b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE  
4 OF LAW OR VENUE.—Nothing in this part shall be con-  
5 strued to—

6 (1) waive or affect any defense of sovereign im-  
7 munity asserted by any State under any provision of  
8 law;

9 (2) waive or affect any defense of sovereign im-  
10 munity asserted by the United States;

11 (3) affect the applicability of any provision of  
12 the Foreign Sovereign Immunities Act of 1976 (28  
13 U.S.C. 1602 et seq.);

14 (4) preempt State choice-of-law rules with re-  
15 spect to actions brought by a foreign nation or a cit-  
16 izen of a foreign nation; or

17 (5) affect the right of any court to transfer  
18 venue or to apply the law of a foreign nation or to  
19 dismiss an action of a foreign nation or of a citizen  
20 of a foreign nation on the ground of inconvenient  
21 forum.

22 **SEC. 147. EFFECTIVE DATE.**

23 This part shall apply to any health care liability ac-  
24 tion initiated after the expiration of the 2-year period that  
25 begins on the date of the enactment of this Act.

1   **PART III—ALTERNATIVE DISPUTE RESOLUTION**  
2                                   **SYSTEMS**

3   **SEC. 148. GRANTS FOR ALTERNATIVE DISPUTE RESOLU-**  
4                                   **TION SYSTEMS.**

5       (a) IN GENERAL.—The Secretary shall make grants  
6 to States from amounts appropriated under section 150  
7 for the development and implementation of alternative dis-  
8 pute resolution systems, under such terms as the Sec-  
9 retary may require.

10      (b) APPLICATION.—

11          (1) IN GENERAL.—No grant may be made  
12 under this section unless an application is submitted  
13 to the Secretary. Any such application shall—

14              (A) be submitted to the Secretary within 1  
15 year after the notification of availability of  
16 funds by the Secretary; and

17              (B) either—

18                  (i) contain a certification by the chief  
19 executive officer of the State that, on the  
20 date the application is submitted, the State  
21 has enacted, adopted, or otherwise has in  
22 effect an alternative dispute resolution sys-  
23 tem; or

24                  (ii) contain a certification by the chief  
25 executive officer of the State that, on the  
26 date the application is submitted, the State

1 plans to develop an alternative dispute res-  
2 olution system.

3 (2) SUPPORTING DOCUMENTATION.—The cer-  
4 tification required—

5 (A) under paragraph (1)(B)(i) shall be ac-  
6 companied by supporting documentation, in-  
7 cluding copies of relevant State statutes, rules,  
8 procedures, regulations, judicial decisions, and  
9 opinions of the State attorney general; and

10 (B) under paragraph (1)(B)(ii) shall be ac-  
11 companied by supporting documentation, in-  
12 cluding a detailed plan of the alternative dis-  
13 pute resolution system to be developed by the  
14 State.

15 (c) REVIEW OF APPLICATIONS.—Within 90 days  
16 after receiving an application under subsection (b), the  
17 Secretary shall review and approve the application if, in  
18 the determination of the Secretary, the application dem-  
19 onstrates that—

20 (1) the State has enacted, adopted, or otherwise  
21 has in effect an alternative dispute resolution sys-  
22 tem; or

23 (2) the State has a plan to develop an alter-  
24 native dispute resolution system.

25 (d) AMOUNT OF GRANT.—

1           (1) IN GENERAL.—The amount of a grant  
2           under this section shall be an amount that the Sec-  
3           retary finds reasonable and necessary for the devel-  
4           opment and implementation of the alternative dis-  
5           pute resolution system of the State.

6           (2) REDUCTIONS FOR EXPENSES OF SUPPLIES,  
7           EQUIPMENT, AND EMPLOYEE DETAIL.—The Sec-  
8           retary may reduce the amount of a grant by—

9                   (A) the fair market value of any supplies  
10                  or equipment furnished to the recipient by the  
11                  Secretary;

12                  (B) the amount of pay, allowances, and  
13                  travel expenses incurred by any officer or em-  
14                  ployee of the Federal Government when such  
15                  officer or employee has been detailed to the re-  
16                  cipient; and

17                  (C) the amount of any other costs incurred  
18                  in connection with the detail of an officer or  
19                  employee as described in subparagraph (B),  
20           when the furnishing of such supplies or equipment  
21           or the detail of such an officer or employee is for the  
22           convenience, and at the request, of such recipient  
23           and for the purpose of carrying out activities under  
24           the grant.



1           (3) OPTION TO REFUSE GRANT.—Not later  
2           than 90 days after the Secretary makes a grant  
3           under this section to a State, that State may send  
4           notice to the Secretary that it refuses the grant. At  
5           the time the State sends such notice, the State shall  
6           return any amounts paid to it under such grant to  
7           the Secretary.

8           (e) SUPPLEMENTAL GRANTS.—If amounts appro-  
9           priated for grants under this section remain available be-  
10          cause—

11           (1) a State has notified the Secretary that it re-  
12          fuses the grant made to the State;

13           (2) a State has notified the Secretary that it  
14          does not intend to use the full amount of a grant  
15          awarded to the State; or

16           (3) the amount paid to a State under a grant  
17          is reduced, offset, or repaid under subsection (d)(2),  
18          the Secretary shall have the discretion to make supple-  
19          mental grants to States, to the extent such amounts are  
20          available, for the implementation of alternative dispute  
21          resolution systems. A grant received by a State under this  
22          subsection shall be used by the State to further implement  
23          and evaluate the effectiveness of such a system.

24          (f) RECORDS.—

1           (1) IN GENERAL.—Each recipient of a grant  
2           under this section shall keep such records as the  
3           Secretary determines appropriate.

4           (2) AUDIT AND EXAMINATION OF RECORDS.—  
5           The Secretary and the Comptroller General of the  
6           United States shall have access to any books, docu-  
7           ments, papers, and records of the recipient of a  
8           grant under this section, for the purpose of conduct-  
9           ing audits and examinations of such recipient that  
10          are pertinent to such grant.

11          (g) REPORTS.—

12           (1) REPORTS ON COMPLIANCE.—

13           (A) SUBMISSION OF REPORTS.—Each  
14           State shall annually submit a report to the Sec-  
15           retary containing such information as the Sec-  
16           retary may require to determine whether the  
17           State is in compliance with the terms of the  
18           grant made under this section.

19           (B) DETERMINATION OF NONCOMPLI-  
20           ANCE.—If, after reviewing the report submitted  
21           under subparagraph (A), the Secretary deter-  
22           mines that a State receiving a grant under this  
23           section is not in compliance with the terms of  
24           the grant, the Secretary shall provide the State

1 with written notice of such determination. Such  
2 notice shall specify—

3 (i) the reasons for the determination  
4 of the Secretary;

5 (ii) that the Secretary will require the  
6 State, not later than 60 days after receipt  
7 of such notice, to return all funds provided  
8 to the State under the grant, unless the  
9 State—

10 (I) takes such corrective action  
11 as may be necessary to ensure that  
12 the State is in compliance with the  
13 terms of the grant; or

14 (II) requests a hearing under  
15 clause (iii); and

16 (iii) that the State may request a  
17 hearing on the record before an adminis-  
18 trative law judge under section 554 of title  
19 5, United States Code, concerning the alle-  
20 gations set forth in the notice.

21 (2) ADDITIONAL REPORTS.—Each State receiv-  
22 ing a grant under this section shall, not later than  
23 2 years after the approval of its application for such  
24 grant and every 2 years thereafter, prepare and sub-  
25 mit to the Commission on National Health Care Ac-

1       cess and Reform established under section 201  
2       (hereafter in this subtitle referred to as the “Com-  
3       mission”), the Secretary, and the appropriate com-  
4       mittees of Congress, a report and evaluation con-  
5       cerning the alternative dispute resolution systems  
6       implemented by the State, including information—

7               (A) on the effect of such systems on the  
8               cost of health care within the State;

9               (B) on the impact of such systems on the  
10              access of individuals to health care within the  
11              State; and

12             (C) on the effect of such systems on the  
13              quality of health care provided within the State;

14   **SEC. 149. ESTABLISHMENT OF ADVISORY PANEL.**

15       (a) IN GENERAL.—The Commission shall make rec-  
16       ommendations to the Secretary concerning the eligibility,  
17       approval, and review requirements for alternative dispute  
18       resolution systems described in applications submitted  
19       under section 148(b).

20       (b) ADVISORS.—The Commission shall—

21             (1) direct the National Advisory Board estab-  
22             lished under section 202 to assist in carrying out the  
23             Commission’s activities under this section; or

1           (2) establish a panel of advisors to assist in car-  
2       rying out the Commission's activities under this sec-  
3       tion.

4       (c) MEMBERS OF THE ADVISORY PANEL.—If the  
5       Commission establishes an advisory panel under sub-  
6       section (b)(2), the members of the advisory panel shall in-  
7       clude representatives from each of the following:

8           (1) Patient advocacy groups.

9           (2) Groups representing State governments.

10          (3) Health care provider groups, including orga-  
11       nized medicine.

12          (4) Health care insurers.

13          (5) Health care employers.

14          (6) Academic researchers from disciplines such  
15       as medicine, economics, law or health services, with  
16       expertise in alternative dispute resolution models.

17       (d) DUTIES OF ADVISORS.—The advisors appointed  
18       under paragraph (1) or (2) of subsection (b) shall—

19           (1) assist in the development of criteria for al-  
20       ternative dispute resolution systems that States  
21       must meet to be eligible to receive grants under sec-  
22       tion 148 and make information on such criteria  
23       available to the States to assist such States in pre-  
24       paring applications for grants;

1           (2) as part of the criteria developed under para-  
2 graph (1), require that the alternative dispute reso-  
3 lution systems for which States receive grants under  
4 section 148—

5                   (A) support access to health care;

6                   (B) encourage improvements in the quality  
7 of care;

8                   (C) enhance the patient-provider relation-  
9 ship;

10                  (D) encourage innovation in health care  
11 delivery systems;

12                  (E) provide prompt resolution and fair  
13 compensation;

14                  (F) provide predictable outcomes; and

15                  (G) operate efficiently in terms of costs  
16 and processes;

17           (3) provide advice and assistance to representa-  
18 tives from State governments concerning the estab-  
19 lishment of alternative dispute resolution systems;

20           (4) not later than 7 years after the date of en-  
21 actment of this Act, submit to the Commission, the  
22 Secretary, and to the appropriate committees of  
23 Congress, a recommendation on the feasibility of a  
24 national alternative dispute resolution system; and

25           (5) perform the duties set forth in part IV.

1       (e) COMPENSATION.—All members of the advisory  
2 panel established under subsection (b)(2) shall be reim-  
3 bursed by the Commission for travel and per diem ex-  
4 penses in lieu of subsistence expenses during the perform-  
5 ance of duties of the Panel in accordance with subchapter  
6 I of chapter 57 of title 5, United States Code.

7       (f) FACA NOT APPLICABLE.—The provisions of the  
8 Federal Advisory Committee Act shall not apply to an ad-  
9 visory panel established under subsection (b)(2).

10       (g) PROVISION OF INFORMATION BY THE SEC-  
11 RETARY.—The Secretary shall make available to the advi-  
12 sors appointed under paragraph (1) or (2) of subsection  
13 (b) any information concerning the grants made under  
14 section 148 that is necessary for such advisors to complete  
15 the duties set forth in subsection (d).

16 **SEC. 150. AUTHORIZATION.**

17       (a) IN GENERAL.—There are authorized to be appro-  
18 priated \$250,000,000 for each of the fiscal years 1994,  
19 1995, and 1996, for grants under section 148.

20       (b) AVAILABILITY OF FUNDS.—Amounts appro-  
21 priated for grants under section 148 shall remain available  
22 until expended.

1   **PART IV—DEMONSTRATION PROJECTS FOR NO-**  
2                   **FAULT COMPENSATION PROGRAMS**

3   **SEC. 151. DEMONSTRATION PROJECTS FOR NO-FAULT COM-**  
4                   **PENSATION PROGRAMS.**

5           (a) ESTABLISHMENT.—The Secretary shall establish  
6 a program to award grants to private entities for the de-  
7 velopment and implementation of demonstration no-fault  
8 compensation programs in the private sector.

9           (b) APPLICATION.—To be eligible to receive a grant  
10 under this section a private entity shall prepare and sub-  
11 mit to the Secretary an application at such time, in such  
12 form, and containing such information as the Secretary  
13 may require including a description of the no-fault com-  
14 pensation program that the private entity intends to de-  
15 velop or implement.

16          (c) REVIEW AND APPROVAL OF APPLICATIONS.—The  
17 Secretary shall review and approve applications received  
18 under subsection (b) in accordance with recommendations  
19 made by the Commission with the advice of the advisors  
20 appointed under section 149(b).

21          (d) AMOUNT OF GRANT.—The amount of a grant to  
22 a private entity under this section shall be an amount that  
23 the Secretary finds reasonable and necessary for the devel-  
24 opment and implementation of the no-fault compensation  
25 program.

26          (e) DUTIES OF ADVISORS.—



1           (1) IN GENERAL.—The advisors appointed  
2       under section 149(b) shall—

3           (A) develop criteria for no-fault compensa-  
4       tion programs in the private sector that private  
5       entities must meet to be eligible to receive  
6       grants under this section; and

7           (B) make information on such criteria  
8       available to the private entities to assist such  
9       entities in preparing applications for grants.

10          (2) CRITERIA.—As part of the criteria devel-  
11       oped under paragraph (1), the advisors shall require  
12       that the no-fault compensation programs for which  
13       States receive grants under this section—

14           (A) provide that health care providers offer  
15       their patients a no-fault compensation scheme  
16       in exchange for a waiver of common law tort li-  
17       ability for all injuries;

18           (B) provide that patients are fully in-  
19       formed of the common law tort rights they are  
20       surrendering and the no-fault benefits they are  
21       eligible to receive; and

22           (C) provide that the health care facility op-  
23       erate an effective quality assurance program,  
24       including measures for reporting and account-

1 ability for all adverse events identified through  
2 this claims process.

3 (f) REPORTS AND RECOMMENDATIONS.—

4 (1) REPORTS BY RECIPIENTS OF GRANTS.—Not  
5 later than 2 years after the approval of its applica-  
6 tion, each private entity that is a grant recipient  
7 shall prepare and submit a report to the Commis-  
8 sion, the Secretary, and the appropriate committees  
9 of Congress, which contains—

10 (A) an analysis of the feasibility and desir-  
11 ability of developing and implementing no-fault  
12 compensation programs; and

13 (B) a recommendation for legislation on  
14 the development and implementation of no-fault  
15 compensation programs.

16 (2) RECOMMENDATIONS.—The Commission  
17 shall review the reports made by grant recipients  
18 pursuant to paragraph (1) and make recommenda-  
19 tions to the Secretary regarding proposals for legis-  
20 lation to develop and implement national no-fault  
21 compensation programs.

22 (g) AUTHORIZATION OF APPROPRIATIONS.—

23 (1) IN GENERAL.—There are authorized to be  
24 appropriated for grants under this section

1       \$20,000,000 for each of the fiscal years 1994, 1995,  
2       and 1996.

3           (2) AVAILABILITY OF FUNDS.—Amounts appro-  
4       priated for grants under this section shall remain  
5       available until expended.

## 6           **Subtitle F—Joint Ventures**

### 7       **SEC. 161. AMENDMENT OF THE NATIONAL COOPERATIVE** 8           **RESEARCH ACT OF 1984.**

9           (a) DEFINITIONS.—Section 2(a) of the National Co-  
10       operative Research Act of 1984 (15 U.S.C. 4301(a)) is  
11       amended by adding at the end the following new para-  
12       graph:

13           “(7) The term ‘joint health care provider ven-  
14       ture’ means a group of activities, as determined by  
15       the Commission on National Health Care Access and  
16       Reform (established under section 201 of the  
17       BasiCare Health Access and Cost Control Act), by  
18       2 or more hospitals for the provision or delivery of  
19       health care services.”.

20       (b) EXCLUSIONS.—Section 2(b) of such Act (15  
21       U.S.C. 4301(b)) is amended—

22           (1) in the matter preceding paragraph (1) by  
23       striking “excludes” and inserting “and the term  
24       ‘joint health care provider venture’ exclude”; and

1           (2) in paragraph (1) by striking “conduct the  
2       research and development that is” and inserting  
3       “carry out”.

4       (c) TECHNICAL AMENDMENTS.—(1) Section 3 of  
5       such Act (15 U.S.C. 4302) is amended by inserting “or  
6       joint health care provider venture” after “joint research  
7       and development venture”.

8       (2) Section 4 of such Act (15 U.S.C. 4303) is amend-  
9       ed in subsections (a)(1), (b)(1), (c)(1), and (e) by insert-  
10      ing “or joint health care provider venture” after “joint  
11      research and development venture” each place it appears.

12      (3) Section 5(a) of such Act (15 U.S.C. 4304(a)) is  
13      amended in the matter preceding paragraph (1) by insert-  
14      ing “or joint health care provider venture” after “joint  
15      research and development venture”.

16      (4) Section 6 of such Act (15 U.S.C. 4305) is  
17      amended—

18           (A) in the heading by striking “RESEARCH AND  
19       DEVELOPMENT”;

20           (B) in subsections (a), (d)(2), and (e) by insert-  
21       ing “or joint health care provider venture” after  
22       “joint research and development venture” each place  
23       it appears; and

24           (C) in the first sentence of subsection (a) by in-  
25       serting “(or in the case of a joint health care pro-

1 vider venture, the date of enactment of the BasiCare  
2 Health Access and Cost Control Act)” after “this  
3 Act”.

4 **TITLE II—LONG-TERM REFORMS**  
5 **Subtitle A—Establishment of**  
6 **Commission and Advisory Board**

7 **SEC. 201. THE COMMISSION ON NATIONAL HEALTH CARE**  
8 **ACCESS AND REFORM.**

9 (a) ESTABLISHMENT.—There is established an inde-  
10 pendent commission to be known as the Commission on  
11 National Health Care Access and Reform (hereinafter re-  
12 ferred to as the “Commission”).

13 (b) DUTIES.—The Commission shall carry out the  
14 duties specified for it in this title.

15 (c) APPOINTMENT.—

16 (1) COMPOSITION.—

17 (A) SIZE AND MANNER OF APPOINT-  
18 MENT.—The Commission shall consist of—

19 (i) five members to be appointed by  
20 the President, by and with the advice and  
21 consent of the Senate, one of whom shall,  
22 at the time of appointment, be designated  
23 as Chairperson of the Commission;

24 (ii) two members to be appointed by  
25 the Speaker of the House of Representa-

1           tives upon the recommendations of the Ma-  
2           jority Leader and Minority Leader of the  
3           House of Representatives; and

4           (iii) two members to be appointed by  
5           the President pro tempore of the Senate  
6           upon the recommendations of the Majority  
7           Leader and Minority Leader of the Senate.

8           (B) POLITICAL AFFILIATION.—At no time  
9           shall more than three of the members appointed  
10          by the President, one of the members appointed  
11          by the Speaker of the House of Representatives,  
12          or one of the members appointed by the Presi-  
13          dent pro tempore of the Senate be members of  
14          the same political party.

15          (C) MEMBERSHIP QUALIFICATIONS.—The  
16          membership of the Commission shall consist of  
17          individuals who are of recognized standing and  
18          distinction and who possess the demonstrated  
19          capacity to discharge the duties imposed on the  
20          Commission, and shall include persons possess-  
21          ing substantial knowledge or expertise in health  
22          care delivery, health care insurance, or health  
23          care economics. No individual who is otherwise  
24          an officer or full-time employee of the United  
25          States shall serve as a member of the Commis-

1           sion. No member while serving on the Commis-  
2           sion may receive financial gain from direct in-  
3           vestments, employment or associations from  
4           any entity with demonstrable financial interest  
5           in matters over which the Commission has ju-  
6           risdiction.

7           (D) CHAIRPERSON.—The Chairperson of  
8           the Commission shall designate a member of  
9           the Commission to act as Vice Chairperson of  
10          the Commission.

11          (E) QUORUM.—A majority of the members  
12          of the Commission shall constitute a quorum,  
13          but a lesser number may conduct hearings.

14          (F) TERM.—Members of the Commission  
15          shall be appointed for a term of 5 years, except  
16          that with respect to the members first ap-  
17          pointed—

18               (i) the Chairperson and 2 members, 1  
19               each appointed under clauses (ii) and (iii)  
20               of paragraph (1)(A), respectively, shall be  
21               appointed for a term of 5 years;

22               (ii) 3 members, 1 each appointed  
23               under clauses (i), (ii) and (iii) of para-  
24               graph (1)(A), respectively, shall be ap-  
25               pointed for a term of 4 years; and

1 (iii) the remaining members shall be  
2 appointed for a term of 3 years.

3 (G) VACANCY.—A vacancy in the Commis-  
4 sion shall not affect its powers, but shall be  
5 filled in the same manner as the original ap-  
6 pointment, but the individual appointed shall  
7 serve only for the unexpired portion of the term  
8 for which the individual's predecessor was ap-  
9 pointed.

10 (2) EFFECTIVE DATE.—Appointments to the  
11 Commission shall be made no later than 90 days  
12 after the date of enactment of this Act.

13 (d) MEETINGS.—The Commission shall meet at the  
14 call of the Chairperson, or at the call of a majority of the  
15 members of the Commission; but meetings shall not be  
16 held less frequently than once in each calendar month  
17 which begins after a majority of the membership of the  
18 Commission has been appointed.

19 (e) HEARINGS.—In carrying out its duties under this  
20 section, the Commission, or any duly authorized commit-  
21 tee thereof, is authorized to hold such hearings, sit and  
22 act at such times and places, and take such testimony,  
23 with respect to matters with respect to which it has a re-  
24 sponsibility under this title, as the Commission or such  
25 committee may deem advisable. The Chairperson of the



1 Commission or any member authorized by the Chairperson  
2 may administer oaths or affirmations to witnesses appear-  
3 ing before the Commission or before any committee there-  
4 of.

5 (f) PAY AND TRAVEL EXPENSES.—

6 (1) PAY.—

7 (A) MEMBERS.—Each member, other than  
8 the Chairperson, shall be paid at a rate equal  
9 to the daily equivalent of the minimum annual  
10 rate of basic pay payable for level IV of the Ex-  
11 ecutive Schedule under section 5315 of title 5,  
12 United States Code, for each day (including  
13 travel time) during which the member is en-  
14 gaged in the actual performance of duties vest-  
15 ed in the Commission.

16 (B) CHAIRPERSON.—The Chairperson  
17 shall be paid for each day referred to in sub-  
18 paragraph (A) at a rate equal to the daily  
19 equivalent of the minimum annual rate of basic  
20 pay payable for level III of the Executive  
21 Schedule under section 5314 of title 5, United  
22 States Code.

23 (2) TRAVEL EXPENSES.—Members shall receive  
24 travel expenses, including per diem in lieu of subsist-

1       ence, in accordance with sections 5702 and 5703 of  
2       title 5, United States Code.

3       (g) STAFF.—

4           (1) APPOINTMENT.—Subject to paragraphs (2)  
5       and (3), the Chairperson, with the approval of the  
6       Commission, may appoint and fix the pay of addi-  
7       tional personnel.

8           (2) INAPPLICABILITY OF CIVIL SERVICE  
9       LAWS.—The Chairperson may make such appoint-  
10      ments without regard to the provisions of title 5,  
11      United States Code, governing appointments in the  
12      competitive service, and any personnel so appointed  
13      may be paid without regard to the provisions of  
14      chapter 51 and subchapter III of chapter 53 of that  
15      title relating to classification and General Schedule  
16      pay rates, except that an individual so appointed  
17      shall receive pay—

18           (A) not less than 120 percent of the mini-  
19      mum rate of basic pay payable for GS-15 of  
20      the General Schedule, and

21           (B) no greater than the rate of basic pay  
22      payable for level IV of the executive schedule.

23           (3) DETAIL OF PERSONNEL FROM FEDERAL  
24      AGENCIES.—Upon request of the Chairperson, the  
25      head of any Federal department or agency may de-

1 tail any of the personnel of that department or agen-  
2 cy to the Commission to assist the Commission in  
3 carrying out its duties under this title.

4 (4) FEDERAL AGENCY ASSISTANCE.—The  
5 Comptroller General of the United States, the Sec-  
6 retary of Health and Human Services, and the Ad-  
7 ministrator of General Services shall provide assist-  
8 ance on a reimbursable basis, including the detailing  
9 of employees, to the Commission in accordance with  
10 an agreement entered into with the Commission.

11 (h) OTHER AUTHORITY.—

12 (1) CONSULTANT SERVICES.—The Commission  
13 may procure by contract, to the extent funds are  
14 available, the temporary or intermittent services of  
15 experts or consultants pursuant to section 3109 of  
16 title 5, United States Code.

17 (2) PROPERTY MATTERS.—The Commission  
18 may lease space and acquire personal property to the  
19 extent funds are available.

20 **SEC. 202. NATIONAL ADVISORY BOARD.**

21 (a) APPOINTMENT.—The Commission shall provide  
22 for appointment of a National Advisory Board (hereinafter  
23 referred to as the “Board”) to advise the Commission on  
24 its activities.

1 (b) MEMBERSHIP.—The Board shall consist of 15  
2 members who are representatives of employers, unions,  
3 health care providers, health care carriers, consumer orga-  
4 nizations, State health programs, and public health profes-  
5 sionals, as well as the general public. Such members shall  
6 serve for terms of 3 years, except that, in the initial ap-  
7 pointment, 5 members shall be each appointed for terms  
8 of 1 year, 2 years, and 3 years.

9 (c) VACANCIES.—

10 (1) IN GENERAL.—The Commission shall fill  
11 any vacancy in the membership of the Board in the  
12 same manner as the original appointment. The va-  
13 cancy shall not affect the power of the remaining  
14 members to execute the duties of the Board.

15 (2) VACANCY APPOINTMENTS.—Any member  
16 appointed to fill a vacancy shall serve for the re-  
17 mainder of the term for which the predecessor of the  
18 member was appointed.

19 (3) REAPPOINTMENT.—The Commission may  
20 reappoint an appointed member of the Board for a  
21 second term in the same manner as the original ap-  
22 pointment.

23 (d) CHAIRPERSON AND VICE CHAIRPERSON.—The  
24 Board shall select a Chairperson and a Vice Chairperson  
25 from among the members of the Board.

1       (e) COMPENSATION.—All members of the Board and  
2 the committees established under subsection (h) shall be  
3 reimbursed by the Commission for travel and per diem in  
4 lieu of subsistence expenses during the performance of du-  
5 ties of the Board in accordance with subchapter I of chap-  
6 ter 57 of title 5, United States Code.

7       (f) FACA NOT APPLICABLE.—The provisions of the  
8 Federal Advisory Committee Act shall not apply to the  
9 Board.

10       (g) DUTIES.—As directed by the Commission, the  
11 Board shall undertake such projects as the Commission  
12 may deem necessary. Such projects may include site visits  
13 and studies that are concerned with issues of access to  
14 health care services, utilization of health care services,  
15 consumer participation and satisfaction in the provision  
16 of health care services, education of health personnel, med-  
17 ical practice, medical technology, quality of insurance  
18 plans and health care delivery, and malpractice liability.  
19 The Board shall not undertake studies, visits, or projects,  
20 nor shall it issue recommendations, except at the request  
21 of the Commission.

22       (h) COMMITTEES.—The Board shall create such com-  
23 mittees (composed of Commission members and others as  
24 appointed by the Chairperson) as necessary to enable the  
25 Board to meet its responsibilities and functions.

1 **SEC. 203. AUTHORIZATION OF APPROPRIATIONS.**

2       There are authorized to be appropriated to the Com-  
3 mission such funds as are necessary to carry out its duties  
4 under this title. Such funds shall remain available until  
5 expended.

6 **Subtitle B—Reform and Standard-**  
7 **ization of Private Insurance**

8 **SEC. 211. DEFINING GOALS AND GUIDELINES OF COMMIS-**  
9 **SION.**

10       (a) **DEFINING GOALS.**—In carrying out the respon-  
11 sibilities assigned to it under this Act, the Commission  
12 shall at all times seek to—

13           (1) improve access to basic health coverage and  
14 services;

15           (2) control the cost of health care coverage and  
16 services;

17           (3) safeguard the quality of health care serv-  
18 ices;

19           (4) assure equity in the availability and cost of  
20 health care coverage and services; and

21           (5) minimize administrative complexity and du-  
22 plication in the health care system.

23       (b) **GUIDELINES.**—In carrying out the responsibil-  
24 ities assigned to it under this Act, the Commission shall  
25 in developing or evaluating any health care proposal or  
26 modification be guided by the anticipated effect on—

1 (1) the cost of health care to medical consum-  
2 ers;

3 (2) the quality of health care services;

4 (3) access to health care services;

5 (4) the financial viability of health care provid-  
6 ers;

7 (5) the financial viability of health care carriers;

8 (6) the provision of health benefits to employees  
9 by employers; and

10 (7) the administrative complexity of the health  
11 care system.

12 (c) CONSULTATIONS.—In carrying out the respon-  
13 sibilities assigned to it under this Act, the Commission  
14 shall seek out and consider recommendations from a broad  
15 range of interested individuals and organizations, includ-  
16 ing organizations representing health care consumers,  
17 health care providers, health care carriers, representatives  
18 of State health programs, public health professionals, and  
19 the general public.

20 **SEC. 212. DEVELOPMENT AND SUBMISSION OF LEGISLA-**  
21 **TIVE PROPOSAL.**

22 (a) IN GENERAL.—By not later than January 1, of  
23 the 2nd year following the date of enactment of this Act,  
24 the Commission shall develop and submit to Congress a  
25 legislative proposal which provides for the following:

1           (1) BASICARE BENEFITS PACKAGE.—A uniform  
2       national health benefits package (hereinafter re-  
3       ferred to as the “BasiCare benefits package”) speci-  
4       fying minimum benefits applicable to all carriers  
5       which meets the requirements of section 214.

6           (2) INSURANCE RESPONSIBILITIES UNDER  
7       BASICARE.—A national health care insurance reform  
8       plan which meets the requirements of section 215  
9       and which shall apply to all carriers selling health  
10      insurance in the United States.

11          (3) ESTABLISHMENT OF BASICARE BASE PRE-  
12      MIUM RATE.—A base premium rate (hereinafter re-  
13      ferred to as the “BasiCare base premium rate”) to  
14      apply to the BasiCare benefits package, which meets  
15      the requirements of section 216.

16          (4) EMPLOYER RESPONSIBILITIES UNDER  
17      BASICARE.—Employer responsibilities to offer the  
18      BasiCare health benefit plan as described in section  
19      217.

20          (5) INDIVIDUAL RESPONSIBILITIES UNDER  
21      BASICARE.—Individual responsibilities to obtain the  
22      BasiCare health benefit plan coverage as described  
23      in section 218.



1           (6) SELF-INSURED REQUIREMENTS.—Self-in-  
2           sured plan requirements with respect to certification  
3           as described in section 219.

4           (7) PROVIDER RESPONSIBILITIES UNDER  
5           BASICARE.—Provider responsibilities under the  
6           BasiCare health benefit plan as described in section  
7           220.

8           (8) TREATMENT OF MANAGED CARE PLANS.—  
9           Federal standards for managed care plans as de-  
10          scribed in section 221 and preemption of State pro-  
11          visions relating to such plans, as described in section  
12          222.

13          (9) LOW-INCOME ASSISTANCE.—A program to  
14          provide low-income individuals and families—

15                (A) an orderly transfer from medicaid pro-  
16                gram coverage under title XIX of the Social Se-  
17                curity Act to BasiCare health benefit plan cov-  
18                erage, and

19                (B) financial assistance in obtaining  
20                BasiCare health benefit plan coverage,  
21                as specified in subtitle C.

22          (b) CONSIDERATION.—The legislative proposal de-  
23          scribed in subsection (a) shall be considered by the Con-  
24          gress under the procedures for consideration of an “ap-  
25          proval resolution” as described in subtitle D.

1 (c) EFFECTIVE DATE OF IMPLEMENTATION.—The  
2 provisions of the recommendation shall become effective  
3 on January 1 of the year following the year of the date  
4 of approval of the Commission's recommendation (unless  
5 such period of time is less than 9 months, in which case  
6 such provisions shall become effective on January 1 of the  
7 second year following the date of approval of the Commis-  
8 sion's recommendation).

9 **SEC. 213. CONTINUING DUTIES AND RESPONSIBILITIES OF**  
10 **THE COMMISSION.**

11 (a) PERIOD FOR RESUBMISSION OF BASICARE PACK-  
12 AGE AND BASE RATE IN CASE OF NONAPPROVAL.—If the  
13 recommendation of the Commission submitted under sec-  
14 tion 212 is not approved by Congress in a year, the Com-  
15 mission shall by not later than January 1 of each year  
16 thereafter, for a period not to exceed 2 years (unless such  
17 recommendation is approved in a year) submit a new rec-  
18 ommendation to Congress subject to the guidelines and  
19 requirements of this title.

20 (b) CONTINUING REVIEW OF BASICARE BENEFITS  
21 PACKAGE AND BASICARE BASE PREMIUM RATE.—

22 (1) MODIFICATIONS IN BASICARE BENEFITS  
23 PACKAGE.—The Commission may by not later than  
24 September 30 of any year following the effective  
25 date of implementation of the Commission's rec-

1       ommendation under section 212, subject to the  
2       guidelines and goals applicable to its initial rec-  
3       ommendation, publish in the Federal Register revi-  
4       sions to the BasiCare benefits package, which revi-  
5       sions shall become effective on January 1 of the im-  
6       mediately following calendar year unless rescinded  
7       by Congress.

8           (2)   MODIFICATIONS   TO   VARIATIONS   IN  
9       BASICARE BASE PREMIUM RATE.—The Commission  
10      may by not later than September 30 of any year fol-  
11      lowing the effective date of implementation of the  
12      Commission’s recommendation under section 212,  
13      subject to the guidelines and goals applicable to its  
14      initial recommendation, publish in the Federal Reg-  
15      ister revisions to any variations provided in the  
16      BasiCare base premium rate, which revisions shall  
17      become effective on January 1 of the immediately  
18      following calendar year unless rescinded by Con-  
19      gress.

20      (c)   ESTABLISHMENT OF ANNUAL ALLOWABLE  
21      RATES OF INCREASE IN BASICARE PREMIUM RATES.—  
22      The Commission shall by not later than September 30 of  
23      each year following the effective date of implementation  
24      of the Commission’s recommendation under section 212,  
25      subject to the guidelines and goals applicable to its initial

1 recommendation, publish in the Federal Register a per-  
2 centage figure for a single allowable rate of increase in  
3 BasiCare premiums to become effective on January 1 of  
4 the immediately following calendar year unless such per-  
5 centage figure is modified or rescinded by Congress. Such  
6 rate of increase shall be binding on all carriers offering  
7 benefits covered under the BasiCare benefits package, as  
8 provided in section 215.

9 (d) OVERSIGHT OF PROVIDER PARTICIPATION.—

10 (1) IN GENERAL.—The Commission shall con-  
11 duct ongoing oversight of provider response to the  
12 imposition of annual limits in the allowable rate of  
13 increase in BasiCare premiums, as provided in this  
14 Act. The findings of such oversight shall be ex-  
15 pressed in annual reports to Congress.

16 (2) CONSIDERATIONS.—Matters to be examined  
17 in such oversight shall include, but are not limited  
18 to, the following:

19 (A) The incidence of participation (or  
20 nonparticipation) of health care providers in  
21 BasiCare health benefit plans.

22 (B) The effect of such participation (or  
23 nonparticipation) on the availability and afford-  
24 ability of health care services to health care  
25 consumers.

1           (C) The extent to which the incidence of  
2           nonparticipation in BasiCare health benefit  
3           plans may vary according to professional spe-  
4           cialty or region.

5           (3) OPTION FOR PARTICIPATION REQUIRE-  
6           MENTS.—At any time following the standardization  
7           of the BasiCare health benefit plan under this Act,  
8           the Commission may submit to Congress a legisla-  
9           tive proposal providing for such participation re-  
10          quirements as the Commission may deem necessary  
11          to assure a level of provider participation in  
12          BasiCare health benefit plans sufficient to assure af-  
13          fordable access to quality health care services by  
14          BasiCare enrollees.

15          (4) CONGRESSIONAL CONSIDERATION.—Any  
16          proposal made to Congress under this subsection  
17          shall be considered by Congress under the proce-  
18          dures for consideration of an “approval resolution”  
19          as described in subtitle D.

20          (e) OVERSIGHT OF SUPPLEMENTAL HEALTH INSUR-  
21          ANCE MARKET.—

22          (1) IN GENERAL.—The Commission shall, upon  
23          implementation of the Commission’s recommenda-  
24          tions under section 212, commence an ongoing as-  
25          sessment of the condition of the supplemental health

1 insurance market for insurance benefits which are  
2 beyond the scope of the BasiCare benefits package.  
3 The findings of such assessment shall be transmitted  
4 in annual reports to the appropriate committees of  
5 Congress.

6 (2) CONSIDERATIONS.—Matters to be ad-  
7 dressed in such assessment shall include, but not be  
8 limited to—

9 (A) the rate of cost growth in the supple-  
10 mental market, and the extent to which such  
11 growth may be contributing to growth in na-  
12 tional health care expenditures;

13 (B) the affordability and availability of  
14 supplemental policies to employers, families,  
15 and individuals;

16 (C) the extent to which the terms and cost  
17 of coverage vary among beneficiaries based on  
18 health and claims status;

19 (D) the value of supplemental policies to  
20 beneficiaries, as measured by loss ratios;

21 (E) the extent of questionable marketing  
22 practices, such as misrepresentation of policy  
23 benefits or provisions, or the selling of policies  
24 that duplicate existing coverage; and

1 (F) the extent to which State insurance  
2 regulation is addressing perceived problems in  
3 the supplemental market.

4 (3) RECOMMENDATION TO CONGRESS.—No  
5 later than January 1 of the second year following  
6 the effective date of implementation of the Commis-  
7 sion's recommendations under this title, the Com-  
8 mission shall include in its annual report to Con-  
9 gress (under this subsection) a recommendation re-  
10 garding the advisability of Federal regulation of the  
11 supplemental health insurance market. If the Com-  
12 mission's recommendation is that such regulation is  
13 needed, the Commission shall prepare and submit to  
14 Congress draft legislation to carry out the terms of  
15 such regulation as it may deem necessary.

16 (4) SUBSEQUENT RECOMMENDATIONS.—At any  
17 time following submission of its recommendation to  
18 Congress under paragraph (3), the Commission may,  
19 based on the findings of its continuing assessment  
20 under paragraphs (1) and (2), submit additional rec-  
21 ommendations or draft legislation to Congress re-  
22 garding action it may consider advisable relative to  
23 the supplemental market.

24 (5) CONGRESSIONAL CONSIDERATION.—Propos-  
25 als made to Congress under this subsection shall be

1 considered by Congress under the procedures for  
2 consideration of an “approval resolution” as de-  
3 scribed in subtitle D.

4 (f) SAFEGUARDING QUALITY OF HEALTH CARE.—

5 (1) ANNUAL REPORT.—The Commission shall  
6 by no later than January 1 of each year following  
7 the date of enactment of this Act, submit an annual  
8 report to Congress assessing the quality of health  
9 care in the United States, and outlining areas of sig-  
10 nificant progress or decline in the delivery of or ac-  
11 cessibility to health care. In preparing such reports,  
12 the Commission shall conduct such studies, hearings,  
13 or other evaluations as it deems necessary to accom-  
14 plish a comprehensive and continuing evaluation of  
15 health care quality in the United States.

16 (2) CONTRACTS FOR PROVISION OF INFORMA-  
17 TION TO CONSUMERS REGARDING QUALITY OF  
18 HEALTH CARE SERVICES AND INSURANCE.—The  
19 Commission shall enter into contracts with the appli-  
20 cable regulatory authority in each State, or such  
21 public or private nonprofit entities as the Commis-  
22 sion deems necessary, for the collection and dissemi-  
23 nation to consumers of information regarding the  
24 quality and cost-effectiveness of services provided by  
25 health care providers and carriers of BasiCare



1 health benefit plans in the State. Such information  
2 shall include—

3 (A) the degree to which a plan's practice  
4 patterns agree with what is known about appro-  
5 priate and inappropriate approaches to health  
6 care,

7 (B) outcome rates for patients with par-  
8 ticular conditions, and

9 (C) patient satisfaction with various as-  
10 pects of a plan's performance.

11 (3) REQUIREMENT TO CONSIDER HEALTH CARE  
12 QUALITY DATA.—Information regarding health care  
13 quality obtained through the activities described in  
14 this subsection shall be considered and incorporated  
15 by the Commission in carrying out the other con-  
16 tinuing duties and responsibilities assigned to it  
17 under this section including setting annual premium  
18 limits and other rates as provided in this title.

19 (g) UNIFORM CLAIMS FORMS AND ELECTRONIC  
20 PROCESSING.—

21 (1) IN GENERAL.—The Commission shall de-  
22 velop in consultation with entities offering health in-  
23 surance, health care providers, and the Secretary, a  
24 uniform claims form to be used by both private

1 health plans and by the medicare program under  
2 title XVIII of the Social Security Act.

3 (2) APPLICATION AND REVISION.—The Com-  
4 mission shall by no later than 1 year after the effec-  
5 tive date of implementation of the Commission's rec-  
6 ommendation under section 212, require that the  
7 uniform claims form developed under paragraph (1),  
8 be utilized by all carriers offering benefits covered  
9 under the BasiCare benefits package and under title  
10 XVIII of the Social Security Act. The Commission  
11 shall revise such form, as necessary, to reflect  
12 changes in the health care insurance market.

13 (3) UNIFORM REPORTING STANDARDS.—In de-  
14 veloping the claims form under paragraph (1), the  
15 Commission in consultation with the entities de-  
16 scribed in such paragraph, shall develop standards  
17 for uniform reporting (while preserving individual  
18 patient identity) concerning—

19 (A) the types and amounts of required  
20 health services provided; and

21 (B) the costs of such facilities providing  
22 such services.

23 The Commission shall periodically collect, analyze,  
24 and disseminate information received under this  
25 paragraph.

1           (4) UNIVERSAL ELECTRONIC PAYMENT AND  
2 BILLING CARD.—In conjunction with development of  
3 the standard claims form under paragraph (1), the  
4 Commission shall develop, and all private and public  
5 health insurance programs shall be required to par-  
6 ticipate in, a program to provide a universal health  
7 insurance card to every individual or family which  
8 shall be accepted by all health care providers for  
9 purposes of payment and billing. Such cards shall be  
10 imprinted electronically with necessary and appro-  
11 priate information concerning coverage and billing,  
12 and to the maximum extent practicable, with infor-  
13 mation to assist in the management of a uniform  
14 system of computerized patient records.

15       (h) LONG-TERM DISPOSITION OF MEDICAID BENE-  
16 FITS AND PROGRAM.—

17           (1) IN GENERAL.—At any time following the ef-  
18 fective date of implementation of the Commission's  
19 recommendation under section 212, the Commission  
20 may submit to Congress a proposed plan for long-  
21 term disposition of any benefits of the medicaid pro-  
22 gram not covered under or subsumed by the  
23 BasiCare benefits package.

24           (2) PROPOSED PLAN.—In preparing a proposed  
25 plan described in paragraph (1), the Commission

1 shall consult with representatives of State medicaid  
2 programs, and shall follow the goals and guidelines  
3 described in section 211.

4 (3) CONGRESSIONAL CONSIDERATION.—Propos-  
5 als made to Congress under this subsection shall be  
6 considered by the Congress under the procedures for  
7 consideration of an “approval resolution” as de-  
8 scribed in subtitle D.

9 (4) PERIOD FOR RESUBMISSION OF PRO-  
10 POSAL.—If the recommendation of the Commission  
11 submitted under this subsection is not approved by  
12 Congress in a year, the Commission shall by not  
13 later than January 1 of each year thereafter, for a  
14 period not to exceed 2 years (unless such rec-  
15 ommendation is approved in a year) submit a new  
16 recommendation to Congress subject to the guide-  
17 lines and requirements of this title.

18 (i) ASSIMILATION OF MEDICARE INTO BASICARE  
19 SYSTEM.—

20 (1) IN GENERAL.—The Commission shall by no  
21 later than January 1 of the fifth year following the  
22 effective date of implementation of the Commission’s  
23 recommendation under section 212, submit to the  
24 Congress draft legislation providing for the assimi-  
25 lation of the medicare program under title XVIII of

1 the Social Security Act into the BasiCare system.  
2 The Commission shall include with such draft legis-  
3 lation, an accompanying report detailing and ex-  
4 plaining the provisions of such draft legislation.

5 (2) CONGRESSIONAL CONSIDERATION.—Propos-  
6 als made to Congress under this subsection shall be  
7 considered by Congress under the procedures for  
8 consideration of an “approval resolution” as de-  
9 scribed in subtitle D.

10 (3) PERIOD FOR RESUBMISSION OF PRO-  
11 POSAL.—If the proposal of the Commission submit-  
12 ted under this subsection is not approved by Con-  
13 gress in a year, the Commission shall by not later  
14 than January 1 of each year thereafter, for a period  
15 not to exceed 2 years (unless such recommendation  
16 is approved in a year) submit a new proposal to  
17 Congress subject to the guidelines and requirements  
18 of this title.

19 (j) ASSIMILATION OF OTHER PROGRAMS INTO  
20 BASICARE SYSTEM.—

21 (1) IN GENERAL.—The Commission shall by no  
22 later than January 1 of the fifth year following the  
23 effective date of implementation of the Commission’s  
24 recommendation under section 212, submit to the

1 Congress draft legislation providing for the assimila-  
2 tion into the BasiCare system of—

3 (A) the veterans health care program  
4 under chapter 17 of title 38, United States  
5 Code,

6 (B) the Civilian Health and Medical Pro-  
7 gram of the Uniformed Services (CHAMPUS),  
8 as defined in section 1073(4) of title 10, United  
9 States Code,

10 (C) the Indian health service program  
11 under the Indian Health Care Improvement Act  
12 (25 U.S.C. 1601 et seq.), and

13 (D) the Federal employees program under  
14 chapter 89 of title 5, United States Code.

15 The Commission shall include with such draft legis-  
16 lation, an accompanying report detailing and ex-  
17 plaining the provisions of such draft legislation.

18 (2) CONGRESSIONAL CONSIDERATION.—Propos-  
19 als made to Congress under this subsection shall be  
20 considered by Congress under the procedures for  
21 consideration of an “approval resolution” as de-  
22 scribed in subtitle D.

23 (3) PERIOD FOR RESUBMISSION OF PRO-  
24 POSAL.—If the proposal of the Commission submit-  
25 ted under this subsection is not approved by Con-

1       gress in a year, the Commission shall by not later  
2       than January 1 of each year thereafter, for a period  
3       not to exceed 2 years (unless such recommendation  
4       is approved in a year) submit a new proposal to  
5       Congress subject to the guidelines and requirements  
6       of this title.

7       (k) OVERSIGHT OF SUCH UNCOMPENSATED CARE AS  
8       MAY REMAIN.—To the extent it deems necessary, and to  
9       the extent practicable, the Commission may provide to  
10      Congress recommendations for the establishment of na-  
11      tional or regional compensation pools, or other mecha-  
12      nisms, for the payment of providers who furnish BasiCare-  
13      covered services to individuals who, through choice or in-  
14      advertence, fail to secure BasiCare coverage as provided  
15      in this Act.

16      (l) MEDICAL EDUCATION ASSISTANCE.—In conjunc-  
17      tion with the duties assigned to it under section 212 of  
18      this Act, and in conjunction with its proposal to assimilate  
19      the medicare program under title XVIII of the Social Se-  
20      curity Act into BasiCare under subsection (i) of this sec-  
21      tion, the Commission shall consider and develop methods  
22      to assure support for academic health centers and the pro-  
23      vision of quality training to health professionals.

24      (m) CERTIFICATION.—

1           (1) IN GENERAL.—The Commission shall re-  
2       quire that no health benefit plan may be offered by  
3       a carrier under section 215 or by an employer under  
4       section 217 or 219 on or after the effective date of  
5       implementation of the Commission’s recommenda-  
6       tion under this title, unless the plan has been cer-  
7       tified by the Commission (in accordance with such  
8       procedures as the Commission establishes) as quali-  
9       fying as a BasiCare health benefit plan. The Com-  
10      mission shall enter into an agreement with the appli-  
11      cable regulatory authority of each State, or such  
12      public or private nonprofit entities as the Commis-  
13      sion deems necessary, to provide for the administra-  
14      tion of such certification under this subsection.

15          (2) LOOK-BEHIND AUTHORITY.—If the Com-  
16      mission determines that a health benefit plan does  
17      not qualify on or after the effective date specified in  
18      paragraph (1), no coverage may be provided under  
19      the plan to individuals not enrolled as of the date of  
20      the determination, and the plan may not be contin-  
21      ued for plan years beginning after the date of such  
22      determination until the Commission determines that  
23      such plan so qualifies.

24          (3) NONAPPLICATION TO SUPPLEMENTAL IN-  
25      SURANCE.—The provisions described in this sub-



1 section shall apply only to coverage for benefits  
2 equivalent to the BasiCare health benefit plan and  
3 do not apply to other health benefits.

4 (n) OVERSIGHT OF PRESCRIPTION DRUGS.—

5 (1) IN GENERAL.—No later than January 1 of  
6 the second year following the effective date of imple-  
7 mentation of the Commission’s recommendations  
8 under this title, the Commission shall submit to  
9 Congress a report regarding the advisability of Fed-  
10 eral regulation of the costs of prescription drugs in  
11 order to maintain the affordability of the BasiCare  
12 benefits package. If the Commission’s recommenda-  
13 tion is that such regulation is needed, the Commis-  
14 sion shall prepare and submit to Congress draft leg-  
15 islation to carry out the terms of such regulation as  
16 it may deem necessary.

17 (2) CONGRESSIONAL CONSIDERATION.—Propos-  
18 als made to Congress under this subsection shall be  
19 considered by Congress under the procedures for  
20 consideration of an “approval resolution” as de-  
21 scribed in subtitle D.

22 **SEC. 214. BASICARE BENEFITS PACKAGE.**

23 (a) CRITERIA.—In preparing the BasiCare benefits  
24 package described in section 212(a)(1), the Commission  
25 shall, subject to the requirements of this title, develop and

1 recommend the BasiCare benefits package as it deems ap-  
2 propriate, adhering to the goals and guidelines described  
3 in this subtitle. The BasiCare benefits package developed  
4 and recommended by the Commission shall at a minimum  
5 provide for—

6 (1) basic hospitalization coverage;

7 (2) basic outpatient services;

8 (3) prescription drugs (subject to reasonable  
9 cost-sharing);

10 (4) protection against catastrophic out-of-pock-  
11 et costs;

12 (5) coverage against extraordinary long-term  
13 care costs; and

14 (6) coverage for preventive care services of sig-  
15 nificant proven and recognized value in averting se-  
16 rious and costly medical conditions.

17 (b) UNIFORMITY.—

18 (1) IN GENERAL.—Subject to the exceptions de-  
19 scribed in paragraph (2), the BasiCare benefits  
20 package recommended by the Commission shall pro-  
21 vide for uniform national deductibles, copayments,  
22 and benefit applications and standards.

23 (2) LIMITED VARIATION ALLOWED.—In order  
24 to accommodate systems for providing health care in  
25 a managed system, the Commission may provide for

1 variations in the structure of BasiCare cost-sharing  
2 requirements for such systems, but only to the ex-  
3 tent such variations do not significantly compromise  
4 the national uniformity of a single BasiCare benefits  
5 package.

6 (c) FLEXIBILITY REGARDING LONG-TERM CARE.—

7 (1) MODIFIED BENEFIT PLAN FOR MEDICARE  
8 BENEFICIARIES.—The Commission may include in  
9 its proposal under section 212 provisions for the es-  
10 tablishment of a modified BasiCare long-term care  
11 benefits plan for persons currently enrolled in the  
12 medicare program under title XVIII of the Social  
13 Security Act. If the Commission includes such a  
14 plan, the plan shall—

15 (A) consist only of long-term care benefits  
16 included in the BasiCare benefits package, and

17 (B) be subject to the rules and require-  
18 ments applicable to the BasiCare health benefit  
19 plan under this title, except as may be modified  
20 by the Commission in its proposal to Congress  
21 under section 212.

22 (2) CONTINUITY OF LONG-TERM CARE COV-  
23 ERAGE.—The Commission may include in its pro-  
24 posal under section 212 such special provisions as it

1 may deem necessary to assure portability of coverage  
2 consistent with the requirements of section 215.

3 (3) INTERACTION WITH OTHER PROGRAMS.—

4 The Commission may include such provisions as it  
5 deems necessary to coordinate BasiCare long-term  
6 care coverage with coverage provided under the med-  
7 icare program under title XVIII of the Social Secu-  
8 rity Act, and with coverage provided by the medicaid  
9 program under title XIX of the Social Security Act,  
10 as modified by the terms of this Act.

11 (d) PREFERENCE FOR COPAYMENTS IN COST-SHAR-  
12 ING.—To the extent practicable, the Commission shall em-  
13 ploy copayments rather than deductibles in providing for  
14 such cost-sharing requirements as may be included in the  
15 BasiCare benefits package under this section.

16 **SEC. 215. INSURANCE RESPONSIBILITIES UNDER**  
17 **BASICARE.**

18 (a) IN GENERAL.—In developing the legislative pro-  
19 posal described in section 212(a)(2), the Commission shall  
20 provide that the requirements of this section are incor-  
21 porated as part of its recommendation for national health  
22 care insurance reform.

23 (b) GENERAL REQUIREMENT.—Each carrier shall  
24 offer the BasiCare health benefit plan as specified in this  
25 section.

1       (c) PREEMPTION OF STATE MANDATED BENEFIT  
2 LAWS.—To the extent that laws of any State or local gov-  
3 ernment regulate or otherwise provide any requirement re-  
4 lating to the benefits to be provided under contracts or  
5 policies of insurance issued to, or under, a BasiCare health  
6 benefit plan, such laws are preempted.

7       (d) NONDUPLICATION OF BASICARE.—Health bene-  
8 fit plans may be issued for benefits other than those cov-  
9 ered by the BasiCare benefits package described in section  
10 214, but no health benefit plans may be offered by any  
11 carrier in any State which duplicate, either in whole or  
12 in part, the benefits described in the BasiCare benefits  
13 package.

14       (e) NONDISCRIMINATION BASED ON HEALTH STA-  
15 TUS.—

16           (1) IN GENERAL.—BasiCare health benefit  
17 plans offered by carriers may not deny, limit, or con-  
18 dition the coverage under (or benefits of) the plan  
19 based on the health status, claims experience, receipt  
20 of health care, medical history, or lack of evidence  
21 of insurability, of an individual.

22           (2) TREATMENT OF PREEXISTING CONDITION  
23 EXCLUSIONS FOR ALL SERVICES.—BasiCare health  
24 benefit plans provided by carriers may not exclude  
25 or otherwise discourage coverage with respect to

1 services related to treatment of a preexisting condi-  
2 tion.

3 (f) REGISTRATION WITH APPLICABLE REGULATORY  
4 AUTHORITY.—

5 (1) IN GENERAL.—Each carrier shall register  
6 with the applicable regulatory authority for each  
7 State in which it issues or offers health benefit  
8 plans.

9 (2) NO PREEMPTION OF STATE INFORMATION  
10 REQUIREMENTS.—Nothing in paragraph (1) shall be  
11 construed as preventing the applicable regulatory  
12 authority from requiring, in the case of BasiCare  
13 carriers that are not self-insurance carriers, such ad-  
14 ditional information in conjunction with, or apart  
15 from, the registration required under paragraph (1)  
16 as the applicable regulatory authority may be au-  
17 thorized to require under State law.

18 (g) GUARANTEED ISSUE.—

19 (1) IN GENERAL.—Subject to the succeeding  
20 provisions of this subsection, a carrier that offers a  
21 BasiCare health benefit plan (including a reinsur-  
22 ance plan) to groups or individuals located in a com-  
23 munity must offer the same plan to any other group  
24 or individual located in the community, and shall  
25 participate in a program developed by the Commis-

1 sion for assigning high-risk groups or individuals  
2 among all such carriers.

3 (2) TREATMENT OF HEALTH MAINTENANCE OR-  
4 GANIZATIONS.—

5 (A) GEOGRAPHIC LIMITATIONS.—A health  
6 maintenance organization may deny coverage  
7 under a BasiCare health benefit plan to an in-  
8 dividual or group whose members are located  
9 outside the service area of the organization, but  
10 only if such denial is applied uniformly without  
11 regard to health status or insurability.

12 (B) SIZE LIMITS.—A health maintenance  
13 organization may apply to the applicable regu-  
14 latory authority to cease enrolling new groups  
15 or individuals in its BasiCare health benefit  
16 plan (or in a geographic area served by the  
17 plan) if it can demonstrate that its financial or  
18 administrative capacity to serve previously en-  
19 rolled groups and individuals (and additional in-  
20 dividuals who will be expected to enroll because  
21 of affiliation with such previously enrolled  
22 groups) will be impaired if it is required to en-  
23 roll new groups or individuals.

24 (3) GROUNDS FOR REFUSAL TO ISSUE OR  
25 RENEW.—

1 (A) IN GENERAL.—A carrier may refuse to  
2 issue or renew or terminate a BasiCare health  
3 benefit plan under this part only for—

- 4 (i) nonpayment of premiums,  
5 (ii) fraud or misrepresentation, and  
6 (iii) failure to meet minimum partici-  
7 pation rates (consistent with subparagraph  
8 (B)).

9 (B) MINIMUM PARTICIPATION RATES.—A  
10 carrier may require, with respect to an employ-  
11 ment-related group BasiCare health benefit  
12 plan, that a minimum percentage of full-time  
13 employees eligible to enroll under the plan be  
14 enrolled, so long as such percentage is enforced  
15 uniformly for all employment groups of com-  
16 parable size.

17 (h) MINIMUM PLAN PERIOD.—A carrier may not  
18 offer, or issue a BasiCare health benefit plan with a term  
19 of less than 12 months.

20 (i) GUARANTEED RENEWABILITY.—

21 (1) IN GENERAL.—

22 (A) GENERAL RULE.—Subject to the suc-  
23 ceeding provisions of this subsection, a carrier  
24 shall ensure that a BasiCare health benefit plan  
25 issued to a group or individual be renewed, at



1 the option of the policyholder, unless the plan  
2 is terminated for the reasons specified in sub-  
3 section (h)(3) (A) or under subparagraph (B).

4 (B) TERMINATION OF BUSINESS.—A car-  
5 rier need not renew a BasiCare health benefit  
6 plan with respect to such a policyholder if the  
7 carrier—

8 (i) is terminating provision of all  
9 health insurance in the community; and

10 (ii) provides notice to the policyholder  
11 covered under the plan of such termination  
12 at least 90 days before the date of expira-  
13 tion of the plan.

14 In the case of such a termination, the carrier  
15 may not provide for issuance of any health ben-  
16 efit plan in such community during the 5-year  
17 period beginning on the date of termination of  
18 such block of business.

19 (C) CONSTRUCTION RESPECTING ADDI-  
20 TIONAL STATE DISCLOSURE REQUIREMENTS.—  
21 Subparagraph (B)(ii) shall not be construed as  
22 preventing the applicable regulatory authority  
23 from specifying the information to be included  
24 in the notice under such subparagraph or in re-

1           quiring such notice to be provided at an earlier  
2           date.

3           (2) NOTICE AND SPECIFICATION OF RATES AND  
4           ADMINISTRATIVE CHANGES.—

5                   (A) NOTICE.—A carrier offering BasiCare  
6           health benefit plans shall provide for notice, at  
7           least 30 days before the date of expiration of  
8           the health benefit plan, of the terms for renewal  
9           of the plan. Except with respect to rates and  
10          administrative changes, the terms of renewal  
11          (including benefits) shall be the same as the  
12          terms of issuance.

13                  (B) RENEWAL RATES SAME AS ISSUANCE  
14          RATES.—The carrier may change the terms for  
15          such renewal, but the premium rates charged  
16          with respect to such renewal shall be the same  
17          as that for a new issue.

18                  (C) RATES CANNOT CHANGE MORE OFTEN  
19          THAN MONTHLY.—

20                   (i) IN GENERAL.—A carrier may not  
21           change the premium rates established with  
22           respect to BasiCare health benefit plans  
23           offered in a community more often than  
24           monthly.

1                   (ii) APPLICATION OF NEW RATES TO  
2                   SPECIFIC PLANS.—With respect to a  
3                   BasiCare health benefit plan which be-  
4                   comes effective in a month, the carrier  
5                   shall ensure that the premium rate estab-  
6                   lished under clause (i) for that month shall  
7                   apply to such plan for all months during  
8                   the 12-month period beginning with that  
9                   month. In the case of a plan renewal which  
10                  is effective for a 12-month period begin-  
11                  ning with a month, the premium rate es-  
12                  tablished under clause (i) with respect to  
13                  that month shall apply to all months dur-  
14                  ing 12-month renewal period.

15               (3) PERIOD OF RENEWAL.—The period of re-  
16               newal of each health benefit plan offered by a carrier  
17               shall be for a period of not less than 12 months.

18               (j) COMMUNITY RATING.—

19               (1) IN GENERAL.—A carrier may not charge  
20               premium rates for BasiCare health benefit plans in  
21               excess of the average per capita cost of providing  
22               such coverage to all individuals covered under  
23               BasiCare policies issued by that carrier in a commu-  
24               nity. A BasiCare health benefit plan meeting such

1 criteria will be considered “actuarially certified” for  
2 purposes of this subsection.

3 (2) ACTUARIALLY CERTIFIED DEFINED.—A  
4 BasiCare health benefit plan is considered to be “ac-  
5 tuarially certified” if there is a written statement by  
6 a member of the American Academy of Actuaries or  
7 other individual acceptable to the applicable regu-  
8 latory authority that a carrier is in compliance with  
9 this section, based upon the individual’s examina-  
10 tion, including a review of the appropriate records  
11 and of the actuarial assumptions and methods uti-  
12 lized by the carrier in establishing premium rates for  
13 applicable health benefit plans.

14 (k) ADJUSTMENTS TO COMMUNITY RATING.—

15 (1) IN GENERAL.—A BasiCare health benefit  
16 plan offered by a carrier to a group or individual  
17 may provide for an adjustment to the average com-  
18 munity rate based on the age of covered individuals.  
19 Any such adjustment shall be applied by the carrier  
20 consistently to all policyholders, and no other adjust-  
21 ments shall be permitted.

22 (2) LIMITATION ON ADJUSTMENT.—

23 (A) IN GENERAL.—The adjustment under  
24 paragraph (1) may not result, with respect to  
25 BasiCare health benefit plans offered by car-

1           riers to groups and individuals in the same  
2           community, in a premium rate for the most ex-  
3           pensive age group exceeding the average com-  
4           munity rate by more than the applicable per-  
5           cent (as defined in subparagraph (B)).

6           (B) APPLICABLE PERCENT DEFINED.—In  
7           subparagraph (A), the term “applicable per-  
8           cent” means—

9                   (i) for the first effective year, 50 per-  
10                  cent,

11                  (ii) for the second effective year, 40  
12                  percent,

13                  (iii) for the third effective year, 30  
14                  percent, and

15                  (iv) for any subsequent year, 20 per-  
16                  cent.

17        (I) APPLICATION OF STANDARDS TO REINSURANCE  
18        POLICIES.—The requirements of this section shall apply  
19        to all reinsurance policies sold by an entity to a carrier  
20        offering BasiCare health benefit plans through self-in-  
21        sured employment-related health benefit plans.

22        (m) APPLICATION OF BASICARE BASE PREMIUM  
23        RATE.—For the first year of standardization of the  
24        BasiCare health benefit plan under this Act, premiums  
25        charged for BasiCare health benefit plans may not exceed

1 the BasiCare base premium rate, as provided in section  
2 216.

3 (n) APPLICATION OF ALLOWED RATE OF IN-  
4 CREASE.—

5 (1) IN GENERAL.—A carrier may not charge  
6 premiums with respect to BasiCare health benefit  
7 plans in any calendar year which exceed the greater  
8 of—

9 (A) the previous year's rate plus the an-  
10 nual allowable percentage rate of increase for  
11 the year as provided in section 213; or

12 (B) the applicable base premium rate, as  
13 provided in section 216, plus amounts cor-  
14 responding to the cumulative total of annual al-  
15 lowable percentage rates of increase up to the  
16 current year.

17 (2) EXCEPTION.—Notwithstanding paragraph  
18 (1)(B), in any single calendar year a carrier may not  
19 increase its premium with respect to a BasiCare  
20 health benefit plan by an amount exceeding 120 per-  
21 cent of the national annual allowable percentage rate  
22 of increase for that year, as provided in section 213.

23 (o) RISK-ADJUSTMENT STRUCTURE.—In preparing  
24 its recommendation to Congress under section 212 of this  
25 Act, the Commission shall provide guidelines for a risk-

1 adjustment structure under which all BasiCare health  
2 benefit plans in a State are assigned a numerical risk  
3 index based on risk-adjustment factors developed by the  
4 Commission and based on such index low-risk carriers are  
5 required to pay an assessment and high-risk carriers are  
6 designated to receive a subsidy in order to balance the risk  
7 of doing business in such State. The Commission shall ad-  
8 minister such a risk-adjustment structure in any State in  
9 which the applicable regulatory authority fails to do so.

10 **SEC. 216. BASICARE BASE PREMIUM RATE.**

11 (a) CRITERIA.—In developing the legislative proposal  
12 described in section 212(a)(3), the BasiCare base pre-  
13 mium rate established and recommended by the Commis-  
14 sion shall be based on the anticipated average cost of pro-  
15 viding the BasiCare benefits package to an average group  
16 of beneficiaries (as determined by the Commission in con-  
17 sultation with the Board).

18 (b) LIMITED VARIATION ALLOWED.—In establishing  
19 the BasiCare base premium rate, the Commission may  
20 propose limited variations in such rate to accommodate  
21 geographic variables, or other variables as described in  
22 paragraphs (1) and (2).

23 (1) GEOGRAPHIC VARIABLES.—In order to ac-  
24 commodate differences in costs in delivering health  
25 care in different geographical areas, the Commission

1 may provide for limited geographical variations in  
2 the BasiCare base premium rate to the extent such  
3 variations are—

4 (A) based on statistically verifiable dif-  
5 ferences in the cost of providing the BasiCare  
6 benefits package, and

7 (B) not provided for geographic areas  
8 smaller than areas that encompass at least—

9 (i) one or more adjacent metropolitan  
10 statistical areas (as defined by the Com-  
11 mission, in consultation with the Bureau of  
12 the Census); or

13 (ii) the total remaining area within a  
14 State not otherwise included in a geo-  
15 graphic area described under clause (i).

16 (2) OTHER VARIABLES.—If the Commission has  
17 provided for variation in the BasiCare benefits pack-  
18 age under paragraph (2) of section 214(b), the Com-  
19 mission may provide for variations in the BasiCare  
20 base premium rate to reflect such variations in the  
21 benefit package, to the extent such variations meet  
22 the criteria for allowing variations under paragraph  
23 (2) of such section. Also, to the extent that adjust-  
24 ments to community rating of BasiCare health bene-  
25 fit plans are permitted under section 215(k), the



1 Commission may provide for corresponding variation  
2 in the BasiCare base premium rate to reflect such  
3 permitted adjustments. If variations are provided for  
4 in the BasiCare base premium rate, such variations  
5 shall be expressed in terms of percentage variation  
6 from a single standard national rate.

7 **SEC. 217. EMPLOYER RESPONSIBILITIES UNDER BASICARE.**

8 In developing the legislative proposal described in sec-  
9 tion 212(a)(4), the Commission shall require the following:

10 (1) NO DISCRIMINATION BASED ON HEALTH  
11 STATUS FOR CERTAIN SERVICES.—An employment-  
12 related BasiCare health benefit plan may not deny,  
13 limit, or condition coverage based on the health sta-  
14 tus, claims experience, receipt of health care, medi-  
15 cal history, or lack of evidence of insurability, of an  
16 individual.

17 (2) TREATMENT OF PREEXISTING CONDITION  
18 EXCLUSIONS.—An employment-related BasiCare  
19 health benefit plan may not exclude or otherwise dis-  
20 courage coverage with respect to services related to  
21 treatment of a preexisting condition.

22 (3) TREATMENT OF WAITING PERIODS.—An  
23 employment-related BasiCare health benefit plan  
24 may not impose waiting periods of any length.

1           (4) NO DISCRIMINATION BASED ON INCOME  
2     LEVEL.—An employment-related BasiCare health  
3     benefit plan shall apply equally to employees of all  
4     income levels.

5           (5) EQUAL CONTRIBUTION LEVELS.—The total  
6     amount of an employer's contribution to the cost of  
7     coverage under an employment-related BasiCare  
8     health benefit plan for employees with incomes less  
9     than 200 percent of the income official poverty line  
10    (as described in section 232(g)(1)) shall equal or ex-  
11    ceed such total amount for employees with incomes  
12    greater than 200 percent of such income official pov-  
13    erty line.

14 **SEC. 218. INDIVIDUAL RESPONSIBILITIES UNDER**  
15 **BASICARE.**

16     Subject to the provisions of subsections (h) and (i)  
17    of section 213, in developing the legislative proposal de-  
18    scribed in section 212(a)(5), the Commission shall require  
19    that to be eligible for benefits under a Federal program,  
20    an individual seeking benefits under such program shall  
21    certify to the administrator of such program that such in-  
22    dividual and the dependents of such individual possess  
23    BasiCare health insurance coverage that meets the appli-  
24    cable minimum standards under this title. Except as may  
25    be provided by the Commission under section 214(c)(1),

1 this section shall not apply to persons eligible for enroll-  
2 ment in—

3 (1) the medicare program under title XVIII of  
4 the Social Security Act,

5 (2) the veterans health care program under  
6 chapter 17 of title 38, United States Code,

7 (3) the Civilian Health and Medical Program of  
8 the Uniformed Services (CHAMPUS), as defined in  
9 section 1073(4) of title 10, United States Code,

10 (4) the Indian health service program under the  
11 Indian Health Care Improvement Act (25 U.S.C.  
12 1601 et seq.), and

13 (5) the Federal employees program under chap-  
14 ter 89 of title 5, United States Code.

15 **SEC. 219. SELF-INSURED PLAN REQUIREMENTS.**

16 (a) IN GENERAL.—In developing the legislative pro-  
17 posal described in section 212(a)(6), the Commission shall  
18 require that in order to obtain certification as a BasiCare  
19 health benefit plan as provided in section 213(m), a self-  
20 insured health benefit plan must demonstrate to the satis-  
21 faction of the Commission that—

22 (1) the benefits and conditions of such plan (in-  
23 cluding copayments and deductibles) are substan-  
24 tially equivalent to those of a BasiCare health bene-  
25 fit plan as provided under this Act;

1           (2) the self-insuring entity is adhering to non-  
2       discrimination standards substantially equivalent to  
3       those provided for carriers in section 215 (insurance  
4       reform requirements) and described in subsection  
5       (b);

6           (3) the average per capita cost of providing  
7       BasiCare equivalent benefits to enrollees in the self-  
8       insured plan differs no more than 10 percent (either  
9       above or below) from the average per capita cost of  
10      providing BasiCare benefits package to non-self-in-  
11      sured beneficiaries in the community (or commu-  
12      nities) in which the self-insured group is located  
13      (without taking into account any reductions in costs  
14      due to health promotion activities of the employer);  
15      and

16          (4) the self-insuring entity possesses adequate  
17      financial reserves, as determined by the Commission,  
18      to assure the immediate and long-term solvency of  
19      the entity and the benefits of individuals receiving  
20      coverage through such entity.

21      (b) STANDARDS DESCRIBED.—Standards described  
22      in this subsection shall include (but are not limited to)  
23      the following:

24          (1) NO DISCRIMINATION BASED ON HEALTH  
25      STATUS.—No self-insured BasiCare health benefit

1 plan may deny, limit, or condition the coverage  
2 under (or benefits of) the plan with respect to health  
3 status, claims experience, receipt of health care,  
4 medical history, or lack of evidence of insurability,  
5 of an individual or group.

6 (2) TREATMENT OF PREEXISTING CONDI-  
7 TIONS.—No self-insured BasiCare health benefit  
8 plan may exclude or otherwise discourage coverage  
9 with respect to services related to treatment of a  
10 preexisting condition.

11 (3) WAITING PERIODS.—No self-insured  
12 BasiCare health benefit plan may impose waiting pe-  
13 riods of any length.

14 **SEC. 220. PROVIDER RESPONSIBILITIES UNDER BASICARE.**

15 In developing the legislative proposal described in sec-  
16 tion 212(a)(7), the Commission shall require as a condi-  
17 tion of participation in the BasiCare health benefit plan  
18 by any health care provider the acceptance by such pro-  
19 vider of any payment by BasiCare as full payment for the  
20 service performed.

21 **SEC. 221. DEVELOPMENT OF STANDARDS FOR MANAGED**  
22 **CARE PLANS.**

23 (a) IN GENERAL.—In preparing the legislative pro-  
24 posal described in section 212(a)(8), the Commission, tak-  
25 ing into account recommendations of the Managed Care

1 Advisory Committee (as described in subsection (b)), shall  
2 develop recommended standards that carriers offering  
3 managed care plans should meet with respect to the bene-  
4 fits, coverage, and delivery systems provided under such  
5 plans. Such standards shall encompass the standards by  
6 which managed care entities operate.

7 (b) MANAGED CARE ADVISORY COMMITTEE.—

8 (1) ESTABLISHMENT.—There shall be estab-  
9 lished a Managed Care Advisory Committee (herein-  
10 after referred to as the “Committee”).

11 (2) MEMBERSHIP.—The Committee shall be  
12 composed of 5 members appointed by the Chair-  
13 person of the Commission, each member represent-  
14 ing 1 of the following areas:

15 (A) Health care professionals.

16 (B) Managed care industry.

17 (C) Academia (with specific expertise in  
18 managed care plans).

19 (D) Business management.

20 (E) Organized labor.

21 (3) COMPENSATION.—

22 (A) IN GENERAL.—Members of the Com-  
23 mittee shall serve without compensation.

24 (B) EXPENSES, ETC., REIMBURSED.—

25 While away from their homes or regular places

1 of business on the business of the Committee,  
2 the members may be allowed travel expenses,  
3 including per diem in lieu of subsistence, as au-  
4 thorized by section 5703 of title 5, United  
5 States Code, for persons employed intermit-  
6 tently in Government service.

7 (C) APPLICATION OF ACT.—The provisions  
8 of the Federal Advisory Committee Act (5  
9 U.S.C. App.) shall not apply with respect to the  
10 Committee.

11 (D) SUPPORT.—The Commission shall  
12 supply such necessary office facilities, office  
13 supplies, support services, and related expenses  
14 as necessary to carry out the functions of the  
15 Committee.

16 **SEC. 222. PREEMPTION OF PROVISIONS RELATING TO MAN-**  
17 **AGED CARE.**

18 In developing the legislative proposal described in sec-  
19 tion 212(a)(8), the Commission shall provide that in the  
20 case of a managed care plan meeting the recommended  
21 standards under section 221 that is offered by a carrier,  
22 the following provisions of law are preempted and may not  
23 be enforced against the managed care plan with respect  
24 to a carrier offering such plan:

1           (1) RESTRICTIONS ON REIMBURSEMENT RATES  
2           OR SELECTIVE CONTRACTING.—Any law that re-  
3           stricts the ability of the carrier to negotiate reim-  
4           bursement rates with health care providers or to  
5           contract selectively with one provider or a limited  
6           number of providers.

7           (2) RESTRICTIONS ON DIFFERENTIAL FINAN-  
8           CIAL INCENTIVES.—Any law that limits the financial  
9           incentives that the managed care plan may require  
10          a beneficiary to pay when a non-plan provider is  
11          used on a non-emergency basis.

12          (3) RESTRICTIONS ON UTILIZATION REVIEW  
13          METHODS.—

14                (A) IN GENERAL.—Any law that—

15                   (i) prohibits utilization review of any  
16                   or all treatments and conditions;

17                   (ii) requires that such review be made  
18                   by a resident of the State in which the  
19                   treatment is to be offered or by an individ-  
20                   ual licensed in such State, or by a physi-  
21                   cian in any particular specialty or with any  
22                   board certified specialty of the same medi-  
23                   cal specialty as the provider whose services  
24                   are being rendered;



1 (iii) requires the use of specified  
2 standards of health care practice in such  
3 review or requires the disclosure of the  
4 specific criteria used in such review;

5 (iv) requires payments to providers for  
6 the expenses of responding to utilization  
7 review requests; or

8 (v) imposes liability for delays in per-  
9 forming such review.

10 (B) CONSTRUCTION.—Nothing in subpara-  
11 graph (A)(ii) shall be construed as prohibiting  
12 a State from requiring that utilization review be  
13 conducted by a licensed health care profes-  
14 sional, or requiring that any appeal from such  
15 a review be made by a licensed physician or by  
16 a licensed physician in any particular specialty  
17 or with any board certified specialty of the  
18 same medical specialty as the provider whose  
19 services are being rendered.

20 (4) RESTRICTIONS ON BENEFITS.—Any law  
21 that mandates benefits under the managed care plan  
22 that are greater than the benefits recommended  
23 under the standards developed under section 221.

1 (5) ERISA.—Any provision of the Employee  
2 Retirement Income Security Act to the extent incon-  
3 sistent with the managed care plan.

#### 4 **Subtitle C—Low-Income Assistance**

##### 5 **SEC. 231. TRANSFER FROM MEDICAID TO BASICARE.**

6 (a) IN GENERAL.—In developing the legislative pro-  
7 posal described in section 212(a)(9)(A), the Commission  
8 shall provide for the orderly termination of medicaid pro-  
9 gram coverage under title XIX of the Social Security Act,  
10 to the extent that such coverage duplicates the BasiCare  
11 benefits package.

12 (b) TRANSFER OF COVERED INDIVIDUALS FROM  
13 MEDICAID TO BASICARE.—Such proposal shall require  
14 each State—

15 (1) to notify medicaid beneficiaries of the im-  
16 pending transfer of coverage of such beneficiaries to  
17 the BasiCare program not later than 1 year prior to  
18 the date of transfer from medicaid to the BasiCare  
19 program; and

20 (2) to provide such information and assistance  
21 as may be necessary to assure the enrollment of all  
22 medicaid beneficiaries in BasiCare health benefit  
23 plans upon the establishment of such plans.

1 (c) PROVISIONAL TREATMENT OF MEDICAID BENE-  
2 FITS NOT COVERED BY BASICARE.—Such proposal shall  
3 require—

4 (1) that for a period of 5 years following the  
5 termination of medicaid benefits that duplicate the  
6 BasiCare benefits package, the medicaid program  
7 shall continue to operate with respect to the provi-  
8 sion of any existing benefits which are not covered  
9 under the BasiCare benefits package; and

10 (2) Federal rules and regulations regarding the  
11 medicaid program shall remain in effect during a  
12 transition period subject to such adjustments  
13 deemed necessary by the Commission to carry out  
14 the medicaid-to-BasiCare transfer described in this  
15 section.

16 (d) FINAL DISPOSITION OF MEDICAID BENEFITS.—  
17 Upon expiration of the 5-year transition period described  
18 in subsection (c)(1), Federal funding for any existing med-  
19 icaid benefits which are not covered under the BasiCare  
20 benefits package shall be discontinued, unless Congress  
21 has approved a plan for alternate disposition of such bene-  
22 fits, as provided in section 213.

1 **SEC. 232. LOW-INCOME ASSISTANCE WITH COSTS OF**  
2 **BASICARE INSURANCE.**

3 (a) IN GENERAL.—In developing the legislative pro-  
4 posal described in section 212(a)(9)(B), the Commission  
5 shall provide for a BasiCare public assistance program  
6 (hereafter in this section referred to as “BasiCare Assist”)  
7 which, at a minimum, meets the requirements of the fol-  
8 lowing subsections of this section.

9 (b) ASSISTANCE FOR UNDER-POVERTY FAMILIES.—  
10 In the case of an individual who is a member of an under-  
11 poverty family, BasiCare Assist shall provide for payment  
12 of—

13 (1) premiums charged the individual for cov-  
14 erage under a BasiCare health benefit plan in which  
15 the individual is enrolled; and

16 (2) deductibles and other cost-sharing imposed  
17 on the individual under such plan, other than a per  
18 service copayment, not to exceed \$5 per service, as  
19 determined by the Commission.

20 (c) ASSISTANCE FOR NEAR-POVERTY FAMILIES.—

21 (1) IN GENERAL.—In the case of an individual  
22 who is a member of a near-poverty family, BasiCare  
23 Assist shall provide for payment of the applicable  
24 percentage of any premiums, deductibles, and other  
25 cost-sharing charged the individual for coverage

1 under a BasiCare health benefit plan in which the  
2 individual is enrolled.

3 (2) APPLICABLE PERCENTAGE.—For purposes  
4 of paragraph (1), the term “applicable percentage”  
5 means 100 percent reduced (but not below zero per-  
6 cent) by 10 percentage points for each 10 percent-  
7 age point bracket (or portion thereof) such family’s  
8 income equals or exceeds 100 percent of the income  
9 official poverty line (as defined by the Office of Man-  
10 agement and Budget, and revised annually in ac-  
11 cordance with section 673(2) of the Omnibus Budget  
12 Reconciliation Act of 1981) applicable to a family of  
13 the size involved.

14 (d) ADJUSTMENT OF ASSISTANCE.—The Commission  
15 shall provide for appropriate adjustments to any assist-  
16 ance under this section to reflect partial family coverage  
17 under an employment-related BasiCare health benefit  
18 plan.

19 (e) APPLICATION FOR ASSISTANCE.—BasiCare Assist  
20 shall use a standard Federal application which shall be  
21 as simple in form as possible and understandable to the  
22 average individual, and shall require attachment of such  
23 documentation as deemed necessary by the Commission in  
24 order to ensure eligibility for assistance. Such application  
25 shall be available to any individual or family, may be filed

1 at any time, and as provided in subsection (f), may initiate  
2 coverage under a BasiCare health benefit plan. The Com-  
3 mission shall use, as deemed practicable by the Commis-  
4 sion, any existing forms employed for Federal income tax  
5 filings as an application for BasiCare Assist.

6 (f) ENROLLMENT AT POINT OF APPLICATION.—To  
7 the extent practicable, the Commission shall provide for  
8 the option of enrollment in a BasiCare health benefit plan  
9 as part of the application and approval process for assist-  
10 ance under this section. In providing for such an option,  
11 the Commission may require carriers of BasiCare health  
12 benefit plans to provide such information and assistance  
13 as may be necessary.

14 (g) PAYMENT OF PREMIUMS, DEDUCTIBLES, AND  
15 OTHER COST-SHARING.—BasiCare Assist shall provide to  
16 an individual a voucher for the applicable percentage of  
17 BasiCare premiums, deductibles, and other cost-sharing  
18 for which such individual qualifies under subsection (b)  
19 or (c). Such voucher shall be remitted by the individual  
20 to the carrier of BasiCare health benefit plans (or, in the  
21 case of an employment-related BasiCare health benefit  
22 plan, to the individual's employer) for payment by  
23 BasiCare Assist. Such carrier shall make proper adjust-  
24 ments in billing statements to reflect such individual's re-

1   maintaining premium obligations, deductibles, and other cost-  
2   sharing (if any).

3       (h) DOCUMENTATION OF ELIGIBILITY.—

4           (1) REQUIREMENT FOR FILING OF INCOME  
5   STATEMENT.—In the case of a family which is re-  
6   ceiving assistance under BasiCare Assist for any  
7   month in a year, a member of the family shall file  
8   a statement with the Commission, at such intervals  
9   during such year as the Commission deems nec-  
10   essary, and by not later than April 15 of the follow-  
11   ing year. Such a statement shall provide information  
12   necessary to determine the family income and the  
13   number of family members in the family during the  
14   year.

15          (2) RECONCILIATION OF ASSISTANCE BASED ON  
16   ACTUAL INCOME.—Based on and using the income  
17   reported in the statement filed under paragraph (1)  
18   with respect to a family, the Commission shall com-  
19   pute the amount of assistance that should have been  
20   provided under BasiCare Assist with respect to the  
21   family in the year involved and make proper adjust-  
22   ments in future assistance. If the amount of such  
23   assistance computed is—

24           (A) greater than the amount of assistance  
25       provided, the Commission shall provide for pay-

1           ment to the family involved of an amount equal  
2           to the amount of the deficit, or

3           (B) less than the amount of assistance  
4           provided, the Commission shall require the fam-  
5           ily to pay to the Federal Government (to the  
6           credit of BasiCare Assist) an amount equal to  
7           the amount of the excess payment.

8           (3) DISQUALIFICATION FOR FAILURE TO  
9           FILE.—In the case of any family that is required to  
10          file an information statement under paragraph (1)  
11          for a year and that fails to file such a statement by  
12          the deadline specified by the Commission, no mem-  
13          ber of the family shall be eligible for assistance  
14          under this section after such deadline. The Commis-  
15          sion shall waive the application of this paragraph if  
16          the family establishes, to the satisfaction of the  
17          Commission, good cause for the failure to file the  
18          statement on a timely basis.

19          (4) PENALTIES FOR FALSE INFORMATION.—

20                (A) INTEREST FOR UNDERSTATEMENTS.—

21          Each individual who knowingly understates in-  
22          come reported in an application for assistance  
23          under BasiCare Assist or any statement de-  
24          scribed in paragraph (1), or otherwise makes a  
25          material misrepresentation of information in



1           such an application or statement shall be liable  
2           to the Federal Government for excess payments  
3           made based on such understatement or mis-  
4           representation, and for interest on such excess  
5           payments at a rate specified by the Commis-  
6           sion.

7                   (B) PENALTIES FOR MISREPRESENTATION.—Each individual who knowingly mis-  
8           represents material information in an applica-  
9           tion for assistance under BasiCare Assist or  
10          any statement described in paragraph (1) shall  
11          be liable to the Federal Government for \$1,000  
12          or, if greater, 3 times the excess payments  
13          made based on such misrepresentation.  
14

15           (5) NOTICE OF REQUIREMENT.—The Commis-  
16          sion shall provide for written notice, in March of  
17          each year, of the requirement of paragraph (1) to  
18          each family which received assistance under  
19          BasiCare Assist in any month during the preceding  
20          year and to which such requirement applies.

21           (6) TRANSMITTAL OF INFORMATION.—The Sec-  
22          retary of the Treasury shall transmit annually to the  
23          Commission such information relating to the total  
24          income of individuals and families for the taxable  
25          year ending in the previous year as may be nec-

1       essary to verify the reconciliation of assistance under  
2       BasiCare Assist.

3       (i) DEFINITIONS AND SPECIAL RULES.—For pur-  
4 poses of this section—

5           (1) UNDER-POVERTY FAMILY.—The term  
6       “under-poverty family” means a family whose in-  
7 come is less than 100 percent of the income official  
8 poverty line (as defined by the Office of Manage-  
9 ment and Budget, and revised annually in accord-  
10 ance with section 673(2) of the Omnibus Budget  
11 Reconciliation Act of 1981) applicable to a family of  
12 the size involved.

13          (2) NEAR-POVERTY FAMILY.—The term “near-  
14 poverty family” means a family whose income equals  
15 or exceeds 100 percent of the income official poverty  
16 line (as described in paragraph (1)), but is less than  
17 200 percent of such income official poverty line.

18          (3) DETERMINATIONS OF INCOME.—

19           (A) IN GENERAL.—The term “income”  
20 means—

21                   (i) adjusted gross income (as defined  
22 in section 62(a) of the Internal Revenue  
23 Code of 1986), determined without the ap-  
24 plication of paragraphs (6) and (7) of such

1 section and without the application of sec-  
2 tion 162(l) of such Code, plus

3 (ii) the amount of social security ben-  
4 efits (described in section 86(d) of such  
5 Code) which is not includable in gross in-  
6 come under section 86 of such Code.

7 (B) FAMILY INCOME.—The term “family  
8 income” means, with respect to an individual,  
9 the sum of the income for the individual and all  
10 the other family members.

11 (C) FAMILY SIZE.—The family size to be  
12 applied under this section, with respect to fam-  
13 ily income, is the number of individuals in-  
14 cluded in the family for purposes of coverage of  
15 a BasiCare health benefit plan.

16 (D) TIMING OF DETERMINATION.—Income  
17 shall be determined in accordance with one of  
18 the following methods, at the option of the ap-  
19 plicant, for coverage under this section:

20 (i) Multiplying by a factor of 4 the  
21 family income of the applicant for the 3-  
22 month period immediately preceding the  
23 month in which the application for assist-  
24 ance under BasiCare is made.

1 (ii) Determining the family income of  
2 the applicant for the month in which the  
3 application for such assistance is made.

4 (j) EFFECTIVE DATE.—The provisions of this section  
5 shall take effect on the effective date of the legislation de-  
6 scribed in section 212(a) or 213(a) of this Act.

7 **Subtitle D—Congressional Consid-**  
8 **eration of Commission Rec-**  
9 **ommendation**

10 **SEC. 241. RULES GOVERNING CONGRESSIONAL CONSIDER-**  
11 **ATION.**

12 (a) RULES OF HOUSE OF REPRESENTATIVES AND  
13 SENATE.—This section is enacted by the Congress—

14 (1) as an exercise of the rulemaking power of  
15 the House of Representatives and the Senate, re-  
16 spectively, and as such is deemed a part of the rules  
17 of each House, respectively, but applicable only with  
18 respect to the procedure to be followed in that  
19 House in the case of approval resolutions described  
20 in subsection (b), and supersedes other rules only to  
21 the extent that such rules are inconsistent therewith;  
22 and

23 (2) with full recognition of the constitutional  
24 right of either House to change the rules (so far as  
25 relating to the procedure of that House) at any time,

1 in the same manner and to the same extent as in  
2 the case of any other rule of that House.

3 (b) TERMS OF THE RESOLUTION.—For purposes of  
4 section 212(b), the term “approval resolution” means only  
5 a joint resolution of the two Houses of the Congress, pro-  
6 viding in—

7 (1) the matter after the resolving clause of  
8 which is as follows: “That the Congress approves the  
9 recommendations of the Commission on National  
10 Health Care Access and Reform as submitted by the  
11 Commission on \_\_\_\_\_”,  
12 the blank space being filled in with the appropriate  
13 date; and

14 (2) the title of which is as follows: “Joint Reso-  
15 lution approving the recommendation of the Com-  
16 mission on National Health Care Access and Re-  
17 form”.

18 (c) INTRODUCTION AND REFERRAL.—On the day on  
19 which the recommendation of the Commission is transmit-  
20 ted to the House of Representatives and the Senate, an  
21 approval resolution with respect to such recommendation  
22 shall be introduced (by request) in the House of Rep-  
23 resentatives by the Majority Leader of the House, for him-  
24 self and the Minority Leader of the House, or by Members  
25 of the House designated by the Majority Leader of the

1 House, for himself and the Minority Leader of the House,  
2 or by Members of the House designated by the Majority  
3 Leader and Minority Leader of the House; and shall be  
4 introduced (by request) in the Senate by the Majority  
5 Leader of the Senate, for himself and the Minority Leader  
6 of the Senate, or by Members of the Senate designated  
7 by the Majority Leader and Minority Leader of the Sen-  
8 ate. If either House is not in session on the day on which  
9 such recommendation is transmitted, the approval resolu-  
10 tion with respect to such recommendation shall be intro-  
11 duced in the House, as provided in the preceding sentence,  
12 on the first day thereafter on which the House is in ses-  
13 sion. The approval resolution introduced in the House of  
14 Representatives and the Senate shall be referred to the  
15 appropriate committees of each House.

16 (d) AMENDMENTS PROHIBITED.—No amendment to  
17 an approval resolution shall be in order in either the  
18 House of Representatives or the Senate; and no motion  
19 to suspend the application of this subsection shall be in  
20 order in either House, nor shall it be in order in either  
21 House for the Presiding Officer to entertain a request to  
22 suspend the application of this subsection by unanimous  
23 consent.

24 (e) PERIOD FOR COMMITTEE AND FLOOR CONSIDER-  
25 ATION.—

1           (1) IN GENERAL.—Except as provided in para-  
2       graph (2), if the committee or committees of either  
3       House to which an approval resolution has been re-  
4       ferred have not reported it at the close of the 45th  
5       day after its introduction, such committee or com-  
6       mittees shall be automatically discharged from fur-  
7       ther consideration of the approval resolution and it  
8       shall be placed on the appropriation calendar. A vote  
9       on final passage of the approval resolution shall be  
10      taken in each House on or before the close of the  
11      45th day after the approval resolution is reported by  
12      the committees or committee of that House to which  
13      it was referred, or after such committee or commit-  
14      tees have been discharged from further consideration  
15      of the approval resolution. If prior to the passage by  
16      one House of an approval resolution of that House,  
17      that House receives the same approval resolution  
18      from the other House then—

19                (A) the procedure in that House shall be  
20              the same as if no approval resolution had been  
21              received from the other House; but

22                (B) the vote on final passage shall be on  
23              the approval resolution of the other House.

24           (2) COMPUTATION OF DAYS.—For purposes of  
25      paragraph (1), in computing a number of days in ei-

1 ther House, there shall be excluded any day on  
2 which the House is not in session.

3 (f) FLOOR CONSIDERATION IN THE HOUSE OF REP-  
4 RESENTATIVES.—

5 (1) MOTION TO PROCEED.—A motion in the  
6 House of Representatives to proceed to the consider-  
7 ation of an approval resolution shall be highly privi-  
8 leged and not debatable. An amendment to the mo-  
9 tion shall not be in order, nor shall it be in order  
10 to move to reconsider the vote by which the motion  
11 is agreed to or disagreed to.

12 (2) DEBATE.—Debate in the House of Rep-  
13 resentatives on an approval resolution shall be lim-  
14 ited to not more than 20 hours, which shall be di-  
15 vided equally between those favoring and those op-  
16 posing the bill or resolution. A motion further to  
17 limit debate shall not be debatable. It shall not be  
18 in order to move to recommit an approval resolution  
19 or to move to reconsider the vote by which an ap-  
20 proval resolution is agreed to or disagreed to.

21 (3) MOTION TO POSTPONE.—Motions to post-  
22 pone, made in the House of Representatives with re-  
23 spect to the consideration of an approval resolution,  
24 and motions to proceed to the consideration of other  
25 business, shall be decided without debate.



1           (4) APPEALS.—All appeals from the decisions  
2       of the Chair relating to the application of the Rules  
3       of the House of Representatives to the procedure re-  
4       lating to an approval resolution shall be decided  
5       without debate.

6           (5) GENERAL RULES APPLY.—Except to the ex-  
7       tent specifically provided in the preceding provisions  
8       of this subsection, consideration of an approval reso-  
9       lution shall be governed by the Rules of the House  
10      of Representatives applicable to other bills and reso-  
11      lutions in similar circumstances.

12      (g) FLOOR CONSIDERATION IN THE SENATE.—

13           (1) MOTION TO PROCEED.—A motion in the  
14      Senate to proceed to the consideration of an ap-  
15      proval resolution shall be privileged and not debat-  
16      able. An amendment to the motion shall not be in  
17      order, nor shall it be in order to move to reconsider  
18      the vote by which the motion is agreed to or dis-  
19      agreed to.

20           (2) GENERAL DEBATE.—Debate in the Senate  
21      on an approval resolution, and all debatable motions  
22      and appeals in connection therewith, shall be limited  
23      to not more than 20 hours. The time shall be equally  
24      divided between, and controlled by, the Majority  
25      Leader and the Minority Leader or their designees.

1           (3) DEBATE OF MOTIONS AND APPEALS.—De-  
2       bate in the Senate on any debatable motion or ap-  
3       peal in connection with an approval resolution shall  
4       be limited to not more than 1 hour, to be equally di-  
5       vided between, and controlled by, the mover and the  
6       manager of the approval resolution, except that in  
7       the event the manager of the approval resolution is  
8       in favor of any such motion or appeal, the time in  
9       opposition thereto, shall be controlled by the Minor-  
10      ity Leader or his designee. Such leaders, or either of  
11      them, may, from time under their control on the  
12      passage of an approval resolution, allot additional  
13      time to any Senator during the consideration of any  
14      debatable motion or appeal.

15           (4) OTHER MOTIONS.—A motion in the Senate  
16      to further limit debate is not debatable. A motion to  
17      recommit an approval resolution is not in order.

18      (h) POINT OF ORDER REQUIRING SUPERMAJORITY  
19      FOR MODIFICATIONS TO RECOMMENDATION ONCE AP-  
20      PROVED.—

21           (1) IN GENERAL.—It shall not be in order in  
22      the House of Representatives or the Senate to con-  
23      sider any amendment to the provisions of the  
24      BasiCare Health Access and Reform Act except as  
25      provided in paragraph (2).

1           (2) WAIVER.—The point of order described in  
 2           paragraph (1) may be waived or suspended in the  
 3           House of Representatives or the Senate only, by the  
 4           affirmative vote of three-fifths of the Members duly  
 5           chosen and sworn.

## 6                   **Subtitle E—Enforcement** 7                   **Provisions**

8   **SEC. 251. ENFORCEMENT PROVISIONS FOR CARRIERS, PRO-**  
 9                   **VIDERS, AND EMPLOYERS.**

10          (a) IN GENERAL.—Chapter 47 of the Internal Reve-  
 11       nue Code of 1986 (relating to excise taxes on qualified  
 12       pension, etc. plans) is amended by striking section 5000  
 13       and section 5000A (as added by section 106) and inserting  
 14       the following new sections:

15   **“SEC. 5000. FAILURE OF CARRIERS WITH RESPECT TO**  
 16                   **BASICARE INSURANCE.**

17          “(a) GENERAL RULE.—In the case of any carrier of-  
 18       fering any health benefit plan, there is hereby imposed a  
 19       tax on such carrier if such plan fails to qualify as a  
 20       Basicare health benefit plan.

21          “(b) AMOUNT OF TAX.—

22               “(1) IN GENERAL.—The amount of tax imposed  
 23       by subsection (a) by reason of 1 or more failures  
 24       during a taxable year shall be equal to 50 percent  
 25       of the gross premiums received during such taxable

1 year with respect to all health benefit plans issued  
2 by the carrier on whom such tax is imposed.

3 “(2) GROSS PREMIUMS.—For purposes of para-  
4 graph (1), gross premiums shall include any consid-  
5 eration received with respect to any health benefit  
6 contract.

7 “(3) CONTROLLED GROUPS.—For purposes of  
8 paragraph (1)—

9 “(A) CONTROLLED GROUP OF CORPORA-  
10 TIONS.—All corporations which are members of  
11 the same controlled group of corporations shall  
12 be treated as 1 carrier. For purposes of the pre-  
13 ceding sentence, the term ‘controlled group of  
14 corporations’ has the meaning given to such  
15 term by section 1563(a), except that—

16 “(i) ‘more than 50 percent’ shall be  
17 substituted for ‘at least 80 percent’ each  
18 place it appears in section 1563(a)(1), and

19 “(ii) the determination shall be made  
20 without regard to subsections (a)(4) and  
21 (e)(3)(C) of section 1563.

22 “(B) PARTNERSHIPS, PROPRIETORSHIPS,  
23 ETC., WHICH ARE UNDER COMMON CONTROL.—  
24 Under regulations prescribed by the Secretary,  
25 all trades or businesses (whether or not incor-

1           porated) which are under common control shall  
2           be treated as 1 carrier. The regulations pre-  
3           scribed under this subparagraph shall be based  
4           on principles similar to the principles which  
5           apply in the case of subparagraph (A).

6           “(c) LIMITATION ON TAX.—

7           “(1) TAX NOT TO APPLY WHERE FAILURE NOT  
8           DISCOVERED   EXERCISING   REASONABLE   DILI-  
9           GENCE.—No tax shall be imposed by subsection (a)  
10          with respect to any failure for which it is established  
11          to the satisfaction of the Secretary that the carrier  
12          on whom the tax is imposed did not know, and exer-  
13          cising reasonable diligence would not have known,  
14          that such failure existed.

15          “(2) TAX NOT TO APPLY WHERE FAILURES  
16          CORRECTED WITHIN 30 DAYS.—No tax shall be im-  
17          posed by subsection (a) with respect to any failure  
18          if—

19                  “(A) such failure was due to reasonable  
20                  cause and not to willful neglect, and

21                  “(B) such failure is corrected during the  
22                  30-day period beginning on the 1st date any of  
23                  the carriers on whom the tax is imposed knew,  
24                  or exercising reasonable diligence would have  
25                  known, that such failure existed.

1           “(3) WAIVER BY SECRETARY.—In the case of a  
2 failure which is due to reasonable cause and not to  
3 willful neglect, the Secretary may waive part or all  
4 of the tax imposed by subsection (a) to the extent  
5 that the payment of such tax would be excessive rel-  
6 ative to the failure involved.

7           “(d) COMPLIANCE DETERMINATION.—

8           “(1) IN GENERAL.—The Commission on Na-  
9 tional Health Care Access and Reform (hereafter in  
10 this subsection referred to as the ‘Commission’ shall  
11 determine whether any health benefit plan qualifies  
12 as a BasiCare health benefit plan.

13           “(2) STATE AGREEMENTS.—

14           “(A) IN GENERAL.—The Commission may,  
15 in its discretion, enter into an agreement with  
16 any State to provide for the State to make the  
17 initial determination described in paragraph  
18 (1).

19           “(B) STANDARDS.—An agreement may be  
20 entered into under subparagraph (A) only if—

21           “(i) the chief executive officer of the  
22 State requests such agreement be entered  
23 into,

24           “(ii) the Commission determines that  
25 the State agreement will apply to substan-

1 tially all health benefit plans issued in such  
2 State, and

3 “(iii) the Commission determines that  
4 the application of the State agreement will  
5 carry out the purposes of this section.

6 “(3) TERMINATION.—The Commission shall  
7 terminate any agreement if the Commission deter-  
8 mines that the application of the State agreement  
9 ceases to carry out the purposes of this section.

10 “(e) DEFINITIONS.—For purposes of this section the  
11 terms ‘health benefit plan’, ‘BasiCare health benefit plan’,  
12 and ‘carrier’ shall have the same meanings given such  
13 terms under section 271 of the BasiCare Health Access  
14 and Cost Control Act.

15 **“SEC. 5000A. FAILURE OF PROVIDERS WITH RESPECT TO**  
16 **BASICARE INSURANCE.**

17 “(a) GENERAL RULE.—There is hereby imposed a  
18 tax on the failure of any person who provides any service  
19 under a BasiCare health benefit plan to comply with the  
20 requirements of section 220 of the BasiCare Health Ac-  
21 cess and Cost Control Act.

22 “(b) AMOUNT OF TAX.—

23 “(1) IN GENERAL.—The amount of tax imposed  
24 by subsection (a) by reason of 1 or more failures  
25 during a taxable year shall be equal to 50 percent

1 of the gross income received during such taxable  
2 year with respect to all services provided by the per-  
3 son on whom such tax is imposed.

4 “(2) CONTROLLED GROUPS.—For purposes of  
5 paragraph (1)—

6 “(A) CONTROLLED GROUP OF CORPORA-  
7 TIONS.—All corporations which are members of  
8 the same controlled group of corporations shall  
9 be treated as 1 person. For purposes of the pre-  
10 ceding sentence, the term ‘controlled group of  
11 corporations’ has the meaning given to such  
12 term by section 1563(a), except that—

13 “(i) ‘more than 50 percent’ shall be  
14 substituted for ‘at least 80 percent’ each  
15 place it appears in section 1563(a)(1), and

16 “(ii) the determination shall be made  
17 without regard to subsections (a)(4) and  
18 (e)(3)(C) of section 1563.

19 “(B) PARTNERSHIPS, PROPRIETORSHIPS,  
20 ETC., WHICH ARE UNDER COMMON CONTROL.—  
21 Under regulations prescribed by the Secretary,  
22 all trades or business (whether or not incor-  
23 porated) which are under common control shall  
24 be treated as 1 person. The regulations pre-  
25 scribed under this subparagraph shall be based



1 on principles similar to the principles which  
2 apply in the case of subparagraph (A).

3 “(c) LIMITATION ON TAX.—

4 “(1) TAX NOT TO APPLY WHERE FAILURE NOT  
5 DISCOVERED EXERCISING REASONABLE DILI-  
6 GENCE.—No tax shall be imposed by subsection (a)  
7 with respect to any failure for which it is established  
8 to the satisfaction of the Secretary that the person  
9 on whom the tax is imposed did not know, and exer-  
10 cising reasonable diligence would not have known,  
11 that such failure existed.

12 “(2) TAX NOT TO APPLY WHERE FAILURES  
13 CORRECTED WITHIN 30 DAYS.—No tax shall be im-  
14 posed by subsection (a) with respect to any failure  
15 if—

16 “(A) such failure was due to reasonable  
17 cause and not to willful neglect, and

18 “(B) such failure is corrected during the  
19 30-day period beginning on the 1st date any of  
20 the persons on whom the tax is imposed knew,  
21 or exercising reasonable diligence would have  
22 known, that such failure existed.

23 “(3) WAIVER BY SECRETARY.—In the case of a  
24 failure which is due to reasonable cause and not to  
25 willful neglect, the Secretary may waive part or all

1 of the tax imposed by subsection (a) to the extent  
2 that the payment of such tax would be excessive rel-  
3 ative to the failure involved.

4 “(d) COMPLIANCE DETERMINATION.—

5 “(1) IN GENERAL.—The Commission on Na-  
6 tional Health Care Access and Reform (hereafter in  
7 this subsection referred to as the ‘Commission’ shall  
8 determine compliance with the requirements of sec-  
9 tion 220 of the BasiCare Health Access and Cost  
10 Control Act.

11 “(2) STATE AGREEMENTS.—

12 “(A) IN GENERAL.—The Commission may,  
13 in its discretion, enter into an agreement with  
14 any State to provide for the State to make the  
15 initial determination described in paragraph  
16 (1).

17 “(B) STANDARDS.—An agreement may be  
18 entered into under subparagraph (A) only if—

19 “(i) the chief executive officer of the  
20 State requests such agreement be entered  
21 into,

22 “(ii) the Commission determines that  
23 the State agreement will apply to substan-  
24 tially all providers of services under health  
25 benefit plans issued in such State, and

8       “(e) DEFINITIONS.—For purposes of this section the  
9 terms ‘health benefit plan’ and ‘BasiCare health benefit  
10 plan’ shall have the same meanings given such terms  
11 under section 271 of the BasiCare Health Access and Cost  
12 Control Act.

15       “(a) GENERAL RULE.—There is hereby imposed a  
16 tax on the failure of any person to comply with the re-  
17 quirements of sections 217 and 219 of the BasiCare  
18 Health Access and Cost Control Act with respect to any  
19 full-time employee of the person.

21           “(1) IN GENERAL.—The amount of the tax im-  
22           posed by subsection (a) on any failure with respect  
23           to a full-time employee shall be \$50 for each day in  
24           the noncompliance period with respect to such fail-  
25           ure.

1           “(2) NONCOMPLIANCE PERIOD.—For purposes  
2 of this section, the term ‘noncompliance period’  
3 means, with respect to any failure, the period—

4                   “(A) beginning on the date such failure  
5 first occurs, and

6                   “(B) ending on the date such failure is  
7 corrected.

8           “(3) CORRECTION.—A failure of a person to  
9 comply with the requirements of sections 217 and  
10 219 of the BasiCare Health Access and Cost Control  
11 Act with respect to any full-time employee of the  
12 person shall be treated as corrected if—

13                   “(A) such failure is retroactively undone to  
14 the extent possible, and

15                   “(B) the employee is placed in a financial  
16 position which is as good as such employee  
17 would have been in had such failure not oc-  
18 curred.

19 For purposes of applying subparagraph (B), the em-  
20 ployee shall be treated as if the employee had elected  
21 the most favorable coverage in light of the expenses  
22 incurred since the failure first occurred.

23           “(c) LIMITATIONS ON AMOUNT OF TAX.—

24                   “(1) TAX NOT TO APPLY WHERE FAILURE NOT  
25 DISCOVERED      EXERCISING      REASONABLE      DILI-

1       GENCE.—No tax shall be imposed by subsection (a)  
2       on any failure during any period for which it is es-  
3       tablished to the satisfaction of the Secretary that  
4       none of the persons referred to in subsection (d)  
5       knew, or exercising reasonable diligence would have  
6       known, that such failure existed.

7               “(2) TAX NOT TO APPLY TO FAILURES COR-  
8       RECTED WITHIN 30 DAYS.—No tax shall be imposed  
9       by subsection (a) on any failure if—

10              “(A) such failure was due to reasonable  
11              cause and not to willful neglect, and

12              “(B) such failure is corrected during the  
13              30-day period beginning on the first date any of  
14              the persons referred to in subsection (d) knew,  
15              or exercising reasonable diligence would have  
16              known, that such failure existed.

17              “(3) WAIVER BY SECRETARY.—In the case of a  
18       failure which is due to reasonable cause and not to  
19       willful neglect, the Secretary may waive part or all  
20       of the tax imposed by subsection (a) to the extent  
21       that the payment of such tax would be excessive rel-  
22       ative to the failure involved.

23              “(d) LIABILITY FOR TAX.—

1           “(1) IN GENERAL.—Except as otherwise pro-  
2       vided in this subsection, the following shall be liable  
3       for the tax imposed by subsection (a) on a failure:

4           “(A) In the case of a BasiCare health ben-  
5       efit plan other than a multiemployer plan, the  
6       employer.

7           “(B) In the case of a multiemployer plan,  
8       the plan.

9           “(C) Each person who is responsible (other  
10      than in a capacity as an employee) for admin-  
11      istering or providing benefits under the  
12      BasiCare health benefit plan and whose act or  
13      failure to act caused (in whole or in part) the  
14      failure.

15          “(2) SPECIAL RULES FOR PERSONS DESCRIBED  
16      IN PARAGRAPH (1)(C).—A person described in sub-  
17      paragraph (C) (and not in subparagraphs (A) and  
18      (B)) of paragraph (1) shall be liable for the tax im-  
19      posed by subsection (a) on any failure only if such  
20      person assumed (under a legally enforceable written  
21      agreement) responsibility for the performance of the  
22      act to which the failure relates.

23          “(e) DEFINITIONS.—For purposes of this section, the  
24      terms ‘BasiCare health benefit plan’ and ‘full-time em-  
25      ployee’ shall have the same meanings given such terms

1 under section 271 of the BasiCare Health Access and Cost  
2 Control Act.”.

3 (b) CLERICAL AMENDMENTS.—The table of sections  
4 for such chapter 47 is amended by adding at the end  
5 thereof the following new items:

“Sec. 5000. Failure of carriers with respect to BasiCare insurance.

“Sec. 5000A. Failure of providers with respect to BasiCare insurance.

“Sec. 5000B. Failure of employers with respect to BasiCare insurance.”.

6 (c) EFFECTIVE DATE.—The amendments made by  
7 this section shall take effect on the effective date of the  
8 legislation described in section 212(a) or 213(a) of this  
9 Act.

10 **SEC. 252. ENFORCEMENT PROVISION FOR INDIVIDUALS.**

11 (a) IN GENERAL.—Subsection (d) of section 151 of  
12 the Internal Revenue Code of 1986 (relating to allowance  
13 of deductions for personal exemptions) is amended by add-  
14 ing at the end thereof the following new paragraph:

15 “(5) EXEMPTION AMOUNT DISALLOWED FOR  
16 UNINSURED INDIVIDUALS.—The exemption amount  
17 for any individual for such individual’s taxable year  
18 shall be zero, unless the policy number of the  
19 BasiCare health benefit plan (as defined in section  
20 271 of the BasiCare Health Access and Cost Control  
21 Act) for such individual is included in the return

1 claiming such exemption amount for such individ-  
2 ual.”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 this section shall take effect on the effective date of the  
5 legislation described in section 212(a) or 213(a) of this  
6 Act.

## 7 **Subtitle F—Financial Provisions**

### 8 **SEC. 261. BASICARE TRUST FUND.**

9 (a) TRUST FUND ESTABLISHED.—There is hereby  
10 created on the books of the Treasury of the United States  
11 a trust fund to be known as the BasiCare Trust Fund  
12 (hereafter in this section referred to as the “Trust  
13 Fund”). The Trust Fund shall consist of such gifts and  
14 bequests as may be made and such amounts as may be  
15 deposited in, appropriated to, or credited to such Trust  
16 Fund as provided in this section.

17 (b) TRANSFER OF AMOUNTS EQUIVALENT TO CER-  
18 TAIN TAXES.—

19 (1) IN GENERAL.—There are hereby appro-  
20 priated to the Trust Fund amounts equivalent to  
21 100 percent of—

22 (A) 1 percent of the wages (as defined in  
23 section 3121 of the Internal Revenue Code of  
24 1986) paid on or after the first day of the cal-  
25 endar year following the date of the enactment



1 of this Act, and reported to the Secretary of the  
2 Treasury or the Secretary's delegate pursuant  
3 to subtitle F of the Internal Revenue Code of  
4 1986, and

5 (B) 1 percent of the amount of self-em-  
6 ployment income (as defined in section 1402 of  
7 the Internal Revenue Code of 1986) reported to  
8 the Secretary of the Treasury or the Secretary's  
9 delegate on tax returns under subtitle F of the  
10 Internal Revenue Code of 1986 for any taxable  
11 year beginning on or after the first day of the  
12 calendar year following the date of the enact-  
13 ment of this Act.

14 (2) PENALTIES.—There are hereby appro-  
15 priated to the Trust Fund amounts equivalent to  
16 100 percent of the taxes imposed under sections  
17 5000, 5000A, and 5000B of the Internal Revenue  
18 Code of 1986.

19 (3) ADDITIONAL REVENUES.—There are hereby  
20 appropriated to the Trust Fund amounts equivalent  
21 to the additional revenues received in the Treasury  
22 as the result of the amendments made by section  
23 262 of this Act.

24 (4) TRANSFERS BASED ON ESTIMATES.—The  
25 amounts appropriated by paragraphs (1), (2), and

1 (3) shall be transferred from time to time (not less  
2 frequently than monthly) from the general fund in  
3 the Treasury to the Trust Fund, such amounts to be  
4 determined on the basis of estimates by the Sec-  
5 retary of the Treasury of the taxes, specified in such  
6 subparagraphs, paid to or deposited into the Treas-  
7 ury; and proper adjustments shall be made in  
8 amounts subsequently transferred to the extent prior  
9 estimates were in excess of or were less than the  
10 taxes specified in such subparagraphs.

11 (c) TRANSFER OF ADDITIONAL FUNDS.—

12 (1) STATE SHARE OF MEDICAID FUNDING.—

13 (A) IN GENERAL.—On a fiscal year basis,  
14 each State shall remit to the Trust Fund the  
15 State's medicaid share for that fiscal year.

16 (B) STATE'S MEDICAID SHARE.—

17 (i) IN GENERAL.—With respect to any  
18 fiscal year beginning after the applicable  
19 effective date of the legislation described in  
20 section 212(a) or 213(a) of this Act, a  
21 State's medicaid share shall equal the  
22 amount such State expended under title  
23 XIX of the Social Security Act for the fis-  
24 cal year preceding such applicable effective  
25 date for benefits equal to the BasiCare

1           benefits package, as determined by the  
2           Commission, in consultation with the Sec-  
3           retary of Health and Human Services and  
4           State medicaid authorities. Such amount  
5           shall be adjusted each fiscal year by the in-  
6           crease in the Consumer Price Index (as de-  
7           termined by the Department of Labor) for  
8           the previous fiscal year.

9           (ii) AMOUNT UPON COMPLETE ASSIMI-  
10          LATION OF MEDICAID.—The amount other-  
11          wise determined under clause (i) for the  
12          fiscal year beginning after the applicable  
13          effective date of the legislation described in  
14          section 213(h) of this Act shall be in-  
15          creased by the amount such State ex-  
16          pended under title XIX of the Social Secu-  
17          rity Act for the fiscal year preceding such  
18          applicable effective date.

19          (C) COMPLIANCE.—The requirements of  
20          this paragraph shall be subject to the provisions  
21          of section 1904 of the Social Security Act.

22          (2) FEDERAL SHARE OF MEDICAID FUNDING.—  
23          There are hereby appropriated for each fiscal year  
24          described in paragraph (1) the comparable Federal  
25          share expended under title XIX of the Social Secu-

1        rity Act for such fiscal year, as adjusted under para-  
2        graph (1)(B)(i).

3            (3) MEDICARE FUNDS.—All amounts, not oth-  
4        erwise obligated, that remain in the Federal Hos-  
5        pital Insurance Trust Fund and the Federal Supple-  
6        mental Medical Insurance Trust Fund on the appli-  
7        cable effective date of the legislation described in  
8        section 213(i) of this Act shall be transferred to the  
9        Trust Fund.

10          (4) ADDITIONAL FEDERAL FUNDS.—There are  
11        hereby appropriated to the Trust Fund for each fis-  
12        cal year beginning after the applicable effective date  
13        of the legislation described in 213(j) of this Act,  
14        amounts equal to the amounts appropriated with re-  
15        spect to—

16            (A) the veterans health care program  
17            under chapter 17 of title 38, United States  
18            Code,

19            (B) the Civilian Health and Medical Pro-  
20            gram of the Uniformed Services (CHAMPUS),  
21            as defined in section 1073(4) of title 10, United  
22            States Code,

23            (C) the Indian health service program  
24            under the Indian Health Care Improvement Act  
25            (25 U.S.C. 1601 et seq.), and

1 (D) the Federal employees program under  
2 chapter 89 of title 5, United States Code,  
3 as in effect on the day before such applicable effective date, as adjusted under paragraph (1)(B)(i).

5 (5) APPROPRIATION OF ADDITIONAL SUMS.—  
6 There are hereby authorized to be appropriated to  
7 the Trust Fund such additional sums as may be required to make expenditures referred to in subsection (e).

10 (e) EXPENDITURES.—

11 (1) LOW-INCOME ASSISTANCE.—There are hereby authorized and appropriated such sums as are  
12 necessary in each fiscal year for the expenses of the  
13 program described in section 241.

15 (2) ADMINISTRATIVE EXPENSES.—There are hereby appropriated such sums as are authorized  
16 under section 203 for the administrative and other  
17 expenses of the Commission for each fiscal year.

19 (3) TITLE I EXPENDITURES.—Amounts in the  
20 Trust Fund shall be available, as provided in appropriation Acts, for authorized expenditures described  
21 in—  
22

23 (A) sections 330A(h) and 330B(h) of the  
24 Public Health Service Act, as added by sections  
25 111 and 112 of this Act, and

1 (B) sections 150 and 151(g) of this Act.

2 (e) INVESTMENT OF TRUST FUND.—

3 (1) IN GENERAL.—It shall be the duty of the  
4 Secretary of the Treasury to invest such portion of  
5 the Trust Fund as is not, in the Secretary's judg-  
6 ment, required to meet current withdrawals. Such  
7 investments may be made only in interest-bearing  
8 obligations of the United States or in obligations  
9 guaranteed as to both principal and interest by the  
10 United States. For such purpose, such obligations  
11 may be acquired—

12 (A) on original issue at the issue price, or

13 (B) by purchase of outstanding obligations  
14 at the market price.

15 The purposes for which obligations of the United  
16 States may be issued under chapter 31 of title 31,  
17 of the United States Code, are hereby extended to  
18 authorize the issuance at par of special obligations  
19 exclusively to the Trust Fund. Such special obliga-  
20 tions shall bear interest at a rate equal to the aver-  
21 age rate of interest, computed as to the end of the  
22 calendar month next preceding the date of such  
23 issue, borne by all marketable interest-bearing obli-  
24 gations of the United States then forming a part of  
25 the Public Debt; except that where such average rate

1 is not a multiple of one-eighth of 1 percent, the rate  
2 of interest of such special obligations shall be the  
3 multiple of one-eighth of 1 percent next lower than  
4 such average rate. Such special obligations shall be  
5 issued only if the Secretary of the Treasury deter-  
6 mines that the purchase of other interest-bearing ob-  
7 ligations of the United States, or of obligations  
8 guaranteed as to both principal and interest by the  
9 United States on original issue or at the market  
10 price, is not in the public interest.

11 (2) SALE OF OBLIGATION.—Any obligation ac-  
12 quired by the Trust Fund (except special obligations  
13 issued exclusively to the Trust Fund) may be sold by  
14 the Secretary of the Treasury at the market price,  
15 and such special obligations may be redeemed at par  
16 plus accrued interest.

17 (3) CREDITS TO TRUST FUND.—The interest  
18 on, and the proceeds from the sale or redemption of,  
19 any obligations held in the Trust Fund shall be  
20 credited to and form a part of the Trust Fund.

21 (f) REPORT TO CONGRESS.—It shall be the duty of  
22 the Secretary of the Treasury to hold the Trust Fund,  
23 and (after consultation with the Commission) to report to  
24 the Congress each year on the financial condition and the  
25 results of the operations of the Trust Fund during the

1 preceding fiscal year and on its expected condition and op-  
2 erations during the next fiscal year. Such report shall be  
3 printed as both a House and Senate document of the ses-  
4 sion of the Congress to which the report is made.

5 (g) CONFORMING AMENDMENT.—Paragraph (4) of  
6 section 201(a) of the Social Security Act (42 U.S.C.  
7 401(a)) is amended by inserting “and section 261(1)(1)  
8 of the BasiCare Health Access and Cost Control Act” be-  
9 fore the end period.

10 **SEC. 262. TAX TREATMENT OF COSTS OF BASICARE INSUR-**  
11 **ANCE.**

12 (a) TAX EXCLUSIONS FOR EMPLOYER-PROVIDED  
13 HEALTH INSURANCE.—Section 106 of the Internal Reve-  
14 nue Code of 1986 (relating to contributions by employer  
15 to accident and health plans) is amended by striking “an  
16 accident or health plan” and inserting “a BasiCare health  
17 benefit plan (as defined in section 271(1) of the BasiCare  
18 Health Access and Cost Control Act)”.

19 (b) BUSINESS EXPENSE DEDUCTION FOR HEALTH  
20 INSURANCE.—Section 162 of the Internal Revenue Code  
21 of 1986 (relating to trade or business expenses) is amend-  
22 ed by redesignating subsection (m) as subsection (n) and  
23 by inserting after subsection (l) the following new sub-  
24 section:



1       “(m) GROUP HEALTH PLANS.—The expenses paid or  
2 incurred by an employer for a group health plan shall not  
3 be allowed as a deduction under this section unless the  
4 plan qualifies as a Basicare health benefit plan (as de-  
5 fined in section 271(1) of the Basicare Health Access and  
6 Cost Control Act).”.

7       (c) RULES RELATING TO DEDUCTIONS FOR INDIVID-  
8 UALS.—

9           (1) DEDUCTION LIMITED TO BASICARE.—Sub-  
10 paragraph (C) of section 213(d)(1) of such Code  
11 (defining medical care) is amended by striking “for  
12 insurance” and inserting “for a Basicare health  
13 benefit plan (as defined in section 271(1) of the  
14 Basicare Health Access and Cost Control Act).”.

15           (2) FULL DEDUCTION ALLOWED.—Section 213  
16 of such Code (relating to medical, dental, etc., ex-  
17 penses) is amended by adding at the end the follow-  
18 ing new subsection:

19       “(g) SPECIAL RULES FOR BASICARE PREMIUM EX-  
20 PENSES.—

21           “(1) IN GENERAL.—The deduction under sub-  
22 section (a) shall be determined without regard to the  
23 limitation based on adjusted gross income with re-  
24 spect to amounts paid for premiums for coverage  
25 under a Basicare health benefit plan (as defined in

1 section 271(1) of the BasiCare Health Access and  
2 Cost Control Act).

3 “(2) LIMIT.—The amount allowed as a deduc-  
4 tion under paragraph (1) with respect to the cost of  
5 providing coverage for any individual shall be re-  
6 duced by the aggregate amount of payments to, or  
7 on behalf of, such individual by—

8 “(A) BasiCare Assist under section 232 of  
9 the BasiCare Health Access and Cost Control  
10 Act, and

11 “(B) all other entities (including any em-  
12 ployer or governmental agency),  
13 for coverage of such individual under a BasiCare  
14 health benefit plan (as so defined).”

15 (3) DEDUCTION ALLOWED AGAINST GROSS IN-  
16 COME.—Section 62(a) of such Code (defining ad-  
17 justed gross income) is amended by inserting after  
18 paragraph (14) the following new paragraph:

19 “(15) DEDUCTION FOR BASICARE PREMIUMS.—  
20 The deduction allowed under section 213(g).”

21 (d) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply with respect to any taxable year  
23 beginning after the applicable effective date of the legisla-  
24 tion described in section 212(a) or 213(a) of this Act.

1                   **Subtitle G—Definitions**

2   **SEC. 271. DEFINITIONS.**

3           For purposes of this title:

4               (1) BASICARE HEALTH BENEFIT PLAN.—The  
5           term “BasiCare health benefit plan” means a health  
6           benefit plan which—

7               (A) offers the BasiCare benefits package  
8               described in section 214;

9               (B) applies the BasiCare base premium  
10           rate described in section 216; and

11              (C) meets the requirements of this title.

12              (2) HEALTH BENEFIT PLAN AND OTHER DEFINI-  
13           TIONS RELATING TO HEALTH PLANS.—For pur-  
14           poses of this section:

15              (A) HEALTH BENEFIT PLAN.—

16                   (i) IN GENERAL.—The term “health  
17           benefit plan” means any hospital or medi-  
18           cal expense incurred policy or certificate,  
19           hospital or medical service plan contract,  
20           health maintenance subscriber contract,  
21           other employee welfare plan (as defined in  
22           the Employee Retirement Income Security  
23           Act of 1964), or any other health insur-  
24           ance arrangement, and includes an employ-

1           ment-related reinsurance plan (as defined  
2           in paragraph (3)).

3           (ii) EXCLUSIONS.—The term ‘health  
4           benefit plan’ does not include—

5                   (I) accident-only, credit, dental,  
6                   or disability income insurance,

7                   (II) coverage issued as a supple-  
8                   ment to liability insurance,

9                   (III) worker’s compensation or  
10                  similar insurance, or

11                  (IV) automobile medical-payment  
12                  insurance;

13          that is offered by a carrier.

14          (B) REINSURANCE PLAN.—The term “re-  
15          insurance plan” means any reinsurance or simi-  
16          lar mechanism that underwrites a portion of the  
17          risk for a health benefit plan.

18          (C) SELF-INSURED HEALTH BENEFIT  
19          PLAN.—The term “self-insured health benefit  
20          plan” means a health benefit plan in which an  
21          employment-related group assumes the under-  
22          writing risk for the plan (whether or not there  
23          is any reinsurance or similar mechanism to un-  
24          derwrite a portion of that risk).

1           (3) CARRIER; HEALTH MAINTENANCE ORGANI-  
2           ZATION; AND OTHER DEFINITIONS RELATING TO  
3           CARRIERS.—For purposes of this title:

4                   (A) CARRIER.—The term “carrier” means  
5           any person that offers a health benefit plan,  
6           whether through insurance or otherwise, includ-  
7           ing a licensed insurance company, a prepaid  
8           hospital or medical service plan, a health main-  
9           tenance organization, a self-insurer carrier, a  
10          reinsurance carrier, and a multiple small em-  
11          ployer welfare arrangement (a combination of  
12          small employers associated for the purpose of  
13          providing health benefit plan coverage for their  
14          employees).

15                  (B) HEALTH MAINTENANCE ORGANIZA-  
16          TION.—The term “health maintenance organi-  
17          zation” has the meaning given the term ‘eligible  
18          organization’ in section 1876(b) of the Social  
19          Security Act, as in effect on the date of enact-  
20          ment of this Act.

21                  (C) REINSURANCE CARRIER.—The term  
22          “reinsurance carrier” means the entity assum-  
23          ing responsibility for underwriting under an  
24          employment-related reinsurance plan, but does

1 not include a carrier insofar as it directly offers  
2 a health benefit plan.

3 (D) SELF-INSURER CARRIER.—The term  
4 “self-insurer carrier” means a carrier that is  
5 not a licensed insurance company, a prepaid  
6 hospital or medical service plan, or a health  
7 maintenance organization, that offers a health  
8 benefit plan directly with respect to an employ-  
9 ment-related group.

10 (4) GENERAL DEFINITIONS.—For purposes of  
11 this title:

12 (A) APPLICABLE REGULATORY AUTHOR-  
13 ITY.—The term “applicable regulatory author-  
14 ity” means, with respect to a health benefit  
15 plan offered in a State, the State commissioner  
16 or superintendent of insurance or other State  
17 authority responsible for regulation of health in-  
18 surance.

19 (B) COMMUNITY.—The term “community”  
20 means a geographic area that encompasses at  
21 least—

22 (i) one or more adjacent metropolitan  
23 statistical areas (as defined by the Com-  
24 mission, in consultation with the Bureau of  
25 the Census); or

1                   (ii) the total remaining area within a  
2                   State not otherwise included in a geo-  
3                   graphic area described under clause (i).

4                   (C) FULL-TIME EMPLOYEE.—The term  
5                   “full-time employee” means, with respect to an  
6                   employer, an employee who normally performs  
7                   on a monthly basis at least 30 hours of service  
8                   per week for such employer.

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